COUNSELING SERVICES FOR OLDER PERSONS AS PERCEIVED AND PROVIDED BY SELECTED FLORIDA AGING PROGRAM ADMINISTRATORS AND DIRECT SERVICE PERSONNEL

BY

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For My Father

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This study investigated the perceptions of Florida Aging Program staff towards counseling services for older persons. How subjects defined counseling, attitudes and perceptions of subjects toward existing services, role of couneling, self-evaluation of training in counseling and gerontology, and rating of counseling against other services were assessed.

An instrument to elicit this information was developed and field tested prior to administration to the whole sample. A 12 item demographic information form and a 61 item questionnaire were constructed. The instrument was administered to 30 persons twice during a two-week period. The resulting test-retest reliability coefficients indicated the instrument to be reliable for all items.

A sample of 414 subjects was identified and chosen at random. Subgroups consisting of program administrators, direct service providers, and purchase of service project staff were included from each of the 11 HRS Districts and the State Aging and Adult Services Program Office in Tallahassee. The researcher or his trained counterpart personally administered the instrument statewide, and 373 usable questionnaires were obtained.

The resulting data were analyzed by computer using Pearson Correlation and One-Way Analysis of Variance procedures. Cross-tabulations of 12 demographic factors and 60 questionnaire item responses are also reported. Item 61 of the instrument and Items 10 and 12 of the demographic form required open-ended responses and these are reported separately.

Each questionnaire item was separately analyzed and responses to it discussed. Differences among sample subgroups, geographic location, and other factors are included. In general, the results indicate that differences in perceptions of counseling services are most notable among State Program Office staff and those in positions which provide direct service care to older persons. Legal and other counseling services were consistently rated below those of other federally funded priority services such as transportation and home services. Subjects tended to evaluate their level of knowledge about older persons as more adequate than their knowledge about counseling. Overall responses tended to support the federally established definition of counseling; however, differences were found in the extent to which subgroups agreed that current programs are fulfilling the definition. Subjects also varied in their evaluation of the current status of counseling services for older persons in aging programs. Differences were found in the evaluation of the role of

counselors and of the use of paraprofessionals, age-peers, or volunteers to provide counseling to the elderly. General agreement was found concerning the adequacy of current services. Subjects largely agreed that counseling services should be de-centralized throughout programs rather than confined specifically to Aging and Adult Services or Mental Health components. Differences were noted between direct service-workers and state level administrators concerning the adequacy of current funding levels to provide improved counseling services for older persons.

The study concludes with a discussion of the results, suggested explanations of the data, implications of the study, and suggestions for further research, counseling, and gerontological training, theory and practice.

CHAPTER I

INTRODUCTION

Background Information

It is well documented that the United States population is rapidly growing older. Over 22 million persons are age 60 or over and they comprise approximately 10% of the total population (Health, Education & Welfare, 1976 - 1977, 1979; Neugarten, 1973; Rose, 1962). By the year 2000, it is estimated that there will be 30,600,000 persons over 65. The state of Florida ranks first in proportion of elderly residents (now more than 20%), and fourth in actual numbers of older persons; and it is experiencing continued rapid migration of additional elderly into the state (Cutler & Haryootan, 1975; Florida, 1974; Giordano & Seaman, 1968; H.E.W., 1977b; Kincaid, 1975). Between the years 1890-1970, Florida's older population experienced a phenomenal 8,041.9% increase. In 1900, 23,086 persons over 60 resided in Florida. In the decade between 1960-1970, this population grew from 774,000 to 1,348,000 (H.E.W., 1977a; United States Bureau of Commerce Bureau of Census, 1972).

A considerable amount of data is now available about the elderly. Demographic data are available about where older persons live, their income levels, health, and education, and their racial, religious, and ethnic backgrounds. Information on their needs, problems, and

opinions has also been gathered, although to a lesser extent (Butler, 1975, Fact Book on Aging, 1978; Harris, 1976).

Much remains to be learend about older persons from both the biological and psycho-social perspectives. In the field of counseling there also exists a considerable void in both research and practice in relation to older persons (Blake, 1975; Boyd & Oakes, 1973; Jackson, 1977; Pressey, 1973; Pressey & Pressey, 1972; Schmidt, 1976).

Many older persons do have significant problems. They experience physical decline, tend to be more conservative than younger persons, and may be more resistant to change. They can experience a sense of greater isolation and loneliness, may be living on reduced and/or fixed incomes, and may lack access to adequate social services. These characteristics, however, are suggestive of only some older persons. In most cases the problems of the aged are more correctly problems of the larger society than of the older persons themselves. Aging in and of itself does not produce poverty or lack of transportation. Such problems are situational and reflect the youth oriented commercialism of our society which rather systematically undervalues the potentials of aging. Older persons are thus frequently denied access to resources and means to meet their needs (Bellak & Karasu, 1976; Boyd & Oakes, 1973; Butler, 1975; Fact Book on Aging, 1978, H.E.W., 1974).

The impact of an aging society on its educational, economic, and social institutions is significant. Much of this information, however, is largely descriptive, categorical, and expressed in numerical and statistical terms. Little has been done to research the basic issues and underlying forces that influence the way older persons age. Existing programs for older persons tend to be fragmented, lacking

in coordination, or duplicative (Butler, 1975; Pfeiffer, 1976; Vasey, 1975). They are frequently planned without reference to any comprehensive study of the issues related to growing older. It is suggested that progress in program development for older persons may be impeded by the negative views of aging and the stereotyped attitudes about older persons that persist in the larger population (Bellak & Karsu, 1976; Florida, 1978c; Harris, 1976; H.E.W., 1975; Tuckman & Lorge, 1953). That these attitudes or "ageism," to use Butler's term, also exist among professionals in the human service field has also been determined by numerous researchers (Burdman, 1974; Colgan, 1976; Frankfather, 1977; Garfinkel, 1975; Keith, 1977; Mutschler, 1971). It has also been noted that the devaluing of older persons by social service personnel can result in their placing lesser importance on the quality and type of services provided to the aged (Bellak & Karasu, 1976; Bennett, 1976; Frankfather, 1977; Vasey, 1975). Exploration of this tendency in terms of perceptions of counseling services for the aged was the purpose of this study.

Need for the Study

This study was prompted by several circumstances relative to the role of counseling services for older persons. First, the counselor role is a logical one to be significantly instrumental in diminishing ageism and in facilitating the delivery of other social services to older persons (Butler, 1975). In addition to providing direct counseling services, counselors can also function as consultants or advisors to other personnel who work with, or on behalf of, the aged. The various concerns of older persons, including social, family, educational, and

retirement, are areas in which counseling expertise can be of significant benefit to the aged (American Personnel and Guidance Association, 1978; Blake, 1975; Bennett, 1976; Boyd & Oakes, 1973; Buckley, 1972; Pressey & Pressey, 1972). However, among the variety of programs and services currently provided for the aged, counseling has only recently been recognized and included. Counseling for older adults has largely been neglected and not developed as a speciality within the profession itself and a paucity of research exists in both theory and field practice (Buckley, 1972; Pressey & Pressey, 1972; Schmidt, 1976; Vontress, 1975).

Second, recent studies have attempted to develop means of assessing the counseling needs of older persons (Ganikos, 1977; Myers, 1978). However, little data have been generated to date. In the interim, it appears valid to assume that older persons' counseling needs are more similar than not to those of persons of other ages, and that they differ more in degree than in kind of need (Boyd & Oakes, 1973; Butler, 1975; Kimmel, 1974; Pfeiffer, 1976). Older persons' expressed needs and their needs as perceived by others may form the basis on which counseling and other social service programs are developed and justified. It is these perceptions, as currently evidenced in the field, of the need for counseling services that this study has investigated.

Third, there is a need for a clarification and acceptance of definitions of counseling in general and for counseling with the elderly specifically. In order for a program to provide counseling services these must be defined in terms of goals, methods, and outcomes. At present, no such precision exists within either the literature or legislation on aging. Consequently, there is considerable "mislabeling"

of other services as counseling (such as financial, tax, and diet counseling) in aging program narratives. Similarly, a variety of personnel in aging programs are given the title of "counselor," although their functions (by both job description and actual practice) include little if any counseling (Florida, 1978a; Florida 1978b; Florida, 1978c; Garfinkel, 1975; H.E.W., 1976). This confusion in definitions does influence the role of counseling services in aging programs.

Fourth, and related to the need for definition, is the problem of accountability for the results of counseling activities. Lack of definition leads to difficulties in demonstrating the effectiveness of counseling in programs. By contrast, it can be clearly demonstrated that certain classes of older persons do not receive adequate nutrition and that this deficiency has certain predictable effects on their health. It is relatively simple to develop a program for meeting this need (Meals-on-Wheels) and then measure the results in terms of numbers served and health benefits to participants. Counseling services are not readily defined and many of the benefits of counseling are difficult, at best, to quantify. Yet, such a mechanism is necessary if these services are to be provided by government funded programs that require such accountability. An assessment of perceptions of counseling services for the aged by those in the field was viewed as needed to form a base-line on which to build a more accurate and favorable impression of counseling and its contributions.

Fifth, counseling services for the elderly have been mandated by federal and state legislation. The Older Americans Act of 1965 and its amendments are the landmark legislation for the majority of aging

programs funded by government sources. Included among the four major areas of need addressed by the Act are transportation, housing, health, and legal and other counseling services. It is noted that the problem of definition may originate in the wording of the Older Americans Act which ties counseling with legal services. Each state is charged with developing a comprehensive plan describing its methodology for provision of services in these four areas. However, the Act leaves to the state the option of deciding for which of the four areas it will plan. States can, legally, concentrate solely on one or two areas, although this is not interpreted as the intent of the Act (Florida, 1977a; Florida, 1977b; H.E.W., 1977a; H.E.W., 1977b). As a result, counseling services have received little attention in terms of both funding and program development. Although a clear mandate exists, counseling services for older persons are not receiving adequate coverage. This is also true of other allied health programs, such as mental health services (Bellak, 1976; Boyd & Oakes, 1973; Frankfather, 1977). There is a need to generate support and acceptance of the value of counseling for older persons so that such services will receive an equitable share of funding and programming along with the more tangible, easily defined, and obvious problems such as food, housing, and transportation.

It is suggested that the attitudes of practitioners and policy makers towards counseling services for the aged influence the degree to which such services are provided. Most federally funded social service agencies include programs designed to meet the needs and alleviate the problems of specific target groups within the large population. Generally, the common denominator for eligible consumers of such services is based on economic classification. Most such programs still have some

form of "means test" as a prerequisite for participation. This is true of some but by no means all aging programs. The majority of programs funded with Older Americans Act monies are without a financial eligibility requirement. Services provided under Title XX of the Social Security Act do have this limitation. Yet, there is a tendency to locate services for the elderly in a central place or agency that is often tied to the low income or welfare population. This practice may tend to reinforce the low esteem with which social service providers view programs for the aged. The "extras," such as counseling, may be perceived as unnecessary frills for programs already considered welfare based and further reinforce the negative attitudes held by providers towards older persons. This aspect of aging programs has been studied with relationship to attitudes towards counseling services for older persons.

In summary, it has been stated that counseling services for older persons have been mandated by law, that monies are available to fund them, and that the programmatic planning system exists to develop these services. Fortunately, some assessments of counseling needs of the aged are being made. That counseling for the aging is not being practiced may be related to the perceptions of policy makers and service providers who believe that such services are not necessary, are not clearly defined, and are difficult to measure. Programs for future generations are being planned now, and if counseling is to be an integral part of them, research must demonstrate why, and attitudes must be changed.

Purpose of the Study

It has been shown that the elderly are currently, and will continue to form, a significant segment of our population. Many of these older persons are or will be potential consumers of a variety of social services. The lack of readily identifiable professional counseling functions in aging programs is perhaps a reflection of the attitudes of those in the field towards such services. This lack of definition of counseling may reinforce the tendency for administrators, social service providers, and agency heads to give counseling a low priority in relation to other services aimed at meeting more measurable human needs. Should counseling be viewed as a catalytic, supportive service adjunctive to other services, its funding status and practice would be enhanced.

Thus, the purpose of this study was to compare and contrast attitudes towards counseling of selected employees in aging programs funded by Florida's Department of Health and Rehabilitative Services. This study has also attempted to determine whether or not a relationship exists between these attitudes and the relative importance given to counseling by program developers, administrators, and direct service personnel. Additionally, the study has attempted to determine with what relative importance subjects viewed counseling as related to other services provided for older persons.

Research Questions

This study has addressed the following research questions:

1. How did the subjects define counseling and how did they differ in their definitions?

2. How did subjects perceive the role of counseling and of counselors in aging programs and how did they differ in their perceptions?
3. How did subjects perceive counseling in relation to other services provided in programs for older persons, and how did they differ in their perceptions?
4. How did subjects evaluate the current status of counseling services in aging projects and programs, and how did they differ in their evaluations?
5. How did subjects rate their own level of knowledge and ability with respect to: needs of the aged, characteristics of the aged, counseling services and techniques for the elderly client, and how did they differ in their self-ratings?

Rationale

Information and conclusions drawn from this study provide a baseline of information relative to the current status of counseling services in Florida's aging programs. Although the generalizability of these results may be limited, their usefulness for planning and comparison purposes should be valuable. Further implications for other research and for program planning can be expected in several areas including administration, funding, and other areas.

The study has implications for counseling in terms of research, theory, practice, and counselor education and the results constitute an addition to the growing specialization in gerontological counseling. The noted lack of definition and accountability for counseling services has been demonstrated and thus counseling for older persons may receive

needed attention. Counselors in training need to be aware of the current services actually being provided and attitudes of administrators and staff in aging programs towards counseling. Those practitioners already in the field may obtain new insight into their positions and the priorities given to counseling services for the aged. New roles for counselors, as consultants and trainers, may be recognized. Finally, the need for further research as well as maintaining professional identity and integrity may be implied.

Implications for the field of gerontology also include a possible clearer delineation of the role of counseling in relation to other social services. Clarification of the role of counseling could lead to its re-evaluation as national, state, and local priorities are established for social services to the elderly. The study has also made needed contributions to the body of gerontological research in that it has provided a field evaluation of gerontological counseling in terms of the application of research and theory.

Participation by the subjects in the study has probably led to their increased awareness of the counseling function for older persons, and has hopefully contributed to the elimination of negative attitudes which may be due to ignorance both of aging process and of counseling. The study has perhaps encouraged participants to become more knowledgeable about both areas. The data generated by this study will be useful to present to state and higher level policy makers and program planners in support of increased counseling services and will encourage full implementation of the federal mandates. Results will provide a base for comparing counseling services in other states.

Finally, it is hoped that the results of the study will contribute to improved quality of services for older persons. Counseling services have a needed and beneficial contribution to make to the welfare of the aged. Perhaps this study can serve to enhance the quality of older persons' lives through improved counseling services and improved attitudes towards these people.

Definition of Terms

The following list refers to terms, acronyms, and agencies, to which frequent reference has been made throughout the study:

- Counseling: A process whereby assistance is given to help resolve social and/or emotional problems through the establishment of a therapeutic relationship and application of skilled interviewing, listening, and problem solving techniques (Florida, 1978b).
- Older Person: A person age 60 or over. The age limit for definition, as "older," "aged," or "elderly" varies between 55 and 65 and above. Sixty appears the most commonly agreed upon age classification (H.E.W., 1977a; Neugarten, 1973).
- Aging Program: Those programs funded by a combination of federal, state, and local monies that are channeled through the Florida Department of Health and Rehabilitative Services and administered by the Office of Aging and Adult Services (including Areawide Agencies on Aging).
- Department of Health and Rehabilitative Services (DHRS or HRS): The umbrella organization that provides a variety of services aimed at promoting the health, social and economic well being of Florida residents.

- Older Americans Act: The initial legislation that mandated and provided funds for major programs and services for older perosns nationwide.
- Employee: Administrative staff in the state program office, administrative staff in the district program offices, Areawide Agency on Aging staff, aging projects staff, specialized adult services staff, and community care project staff.
- Specialized Adult Services (SAS): The direct social services component of Aging and Adult Services offices that provides face-to-face client contact, resulting in the provision of transportation, medical, housekeeping, chore, escort, guardianship, and other services for older persons.

Organization of the Remainder of the Study

The remainder of the study is presented in four additional chapters.

Chapter II provides a review of the current literature on topics germane to the study.

Chapter III describes the methodology used to conduct the research.

Chapter IV presents the results of the study including data analysis.

Chapter V includes a summary, discussion of the results, implications of the study, and suggestions for further research.

CHAPTER II

REVIEW OF THE LITERATURE

Characteristics and Needs of Older Persons

An understanding of the basic needs, characteristics and changes that can accompany growing older is necessary for counselors and other social services providers. Misconceptions about aging and the abilities of older persons can lead to development of negative perceptions. As noted previously, such negative views can influence the type and quality of services provided to older persons. Additionally, there is some evidence that exposure to gerontological information through training and/or contact with older persons does tend to improve unfavorable attitudes (Ernst & Shore, 1975). In order to adequately understand the origins of commonly held stereotyped views of aging and older persons, a review of major areas of need and characteristics of the elderly is necessary. Attention is also directed towards identifying those areas of needs and problems which can be effectively addressed by counselors.

Demographic data and broad categorizations of the older population have been generated by several comprehensive national and state surveys. In recent years, the Harris Poll, Bureau of the Census data, the Florida HRS Needs Assessments, and similar studies have provided an extensive factual foundation. As with most studies involving large numbers of people, generalizations are made which do not necessarily apply to

individual older persons. Some categorization is necessary, however, if needs are to be identified and effective programs developed to meet them.

Several social and economic forces have led to conditions which facilitated the rapid increase in this country's population of older persons. With few exceptions, the fertility rate has continually declined until the United States now approaches a "zero" population growth level. Simultaneously, improvements in nutrition, medical knowledge and services, and control of infant mortality have increased Americans' average age by more than six years since 1900. Further, it is predicted that our population will experience a change from the average age of 23 years in 1900, to an average age of 38 years in 2035 (H.E.W., 1978). It is thus apparent that the problems and issues we face today in dealing with the needs of older persons will continue to be of increasing importance in both the very near future and the coming decades. Prior to a discussion of specific needs of this group, it is important to note that, in general, socio-economic conditions for most older persons can be expected to improve as the population as a whole ages. However, problems will still exist. As one source states, ". . .the segments of the older population that will be growing most rapidly [the oldest of the old, women, and persons of races other than white] will be the same groups that have suffered more from such common problems of the elderly as poor health, social isolation, and poverty" (H.E.W., 1978, p. 8).

Economics, Income and Retirement

Changes in economic status and income level are among the most notable characteristics that can accompany growing older. A reduction

in income generally follows retirement and older families frequently begin to depend upon outside sources of financial assistance. Although by no means are all older persons living in poverty, many must exist on lowered and/or fixed incomes. For example, an estimated one-fourth of older widows subsist on incomes below established governmental poverty levels (H.E.W., 1976). Economic fluctuations also necessitate alterations in other areas including changes in lifestyle, residential relocation, and loss of financial security for emergencies (H.E.W., 1978a).

Reduced incomes frequently require older persons to turn to social service agencies to meet their needs for housing, food, transportation, and medical care. For a generation unaccustomed to receiving financial aid, both the fact of being needy and the process of becoming a recipient of such services can be emotionally devastating (Bellak, 1976; Bennett, 1976; Butler, 1975; Hollender, 1952; Frankfather, 1977). This problem is further compounded by the negative attitudes held by social service providers towards their elderly clients. Although only a minority of older persons are wholly dependent on agency support, many staff workers tend to view all in this way and to see the aged as less capable than they are (Burdman, 1974; Bellak, 1976; Bennett, 1976; Frankfather, 1977). Counselors and counseling techniques could facilitate and humanize agency procedures as well as educate social workers to the needs and sensitivities of older persons with restricted incomes (Boyd & Oakes, 1973; Buckley, 1972; Butler, 1975; Pressey & Pressey, 1972).

Retirement brings a loss of status, social value, and lessened self-esteem as well as a loss of income. These psycho-emotional

changes accompanying retirement can be detrimental to the welfare of older persons (Andersen, 1969; Maddox, 1970; Jackson, 1977). This is particularly true for the current generation of elderly who were reared in an era which placed a high value on work, productivity, and economic independence. The youth and leisure orientation of today's society further devalues the older retirees' position. Not only do they not work, they frequently lack the ability, interests, or means to play successfully (Kleemeier, 1962; Carp, 1972). Retirement, particularly for men, also means a tremendous shift downward in status and in feelings of self-worth. The effects of these changes have been fairly well researched, as have the corresponding changes affecting older women left with the "empty nest" syndrome (Berardo, 1972; Bloom & Munro, 1972; Bock, 1972; McKain, 1969; Shanas, 1969). The need for adequate pre-retirement planning has been stressed and such planning would assist in preventing many of these and related problems which accompany this change. The counselor's role in meeting this need has been described and emphasized by several authors (Andersen, 1969; Baker, 1952; Buckley, 1972; Carp, 1972; Monk, 1971, Schmidt, 1976).

Although retirement may still be mandatory for some older persons today, many wish to continue working either from economic necessity or personal desire. The difficulties faced by middle-aged workers seeking career changes loom even larger for persons past 60. Enforced retirement indicates an attitude that older workers are less necessary, less capable, and should make room for younger employees. As one author suggests, this practice is discriminatory and not based on factual understanding of older persons' vocational abilities (Palmore, 1976). This author has delineated several concepts about the capacities of

older employees. A review of these capacities is helpful in clarifying the origin of many commonly held stereotyped and negative attitudes about mature workers. Palmore notes that age itself should not be the sole criterion for retirement. Increased life span and improved health should encourage employers to retain older workers. Flexible rather than mandatory retirement systems would benefir the economy and allow employers to retain the skills and expertise of older workers. Poor attendance, illness, and lowered safety performance are not inevitably correlated with increasing age among workers. Finally, it is noted that providing late-life career options improves older persons' self-satisfaction and esteem while reducing somewhat the economic hardships imposed by retirement (Palmore, 1976; Rehm, 1971). In summary, it can be seen that these aspects of retirement have significantly contributed to devaluation of older people, particularly in economic terms.

The older person seeking a new career or retraining for a post-retirement job also may encounter resistance and problems. Social service and rehabilitation agencies tend to give older applicants low priority despite considerable research evidence that their potential for successful placement is realistically high (Donahue, Rae, & Berry, 1953; Ernst & Shore, 1975; Rasch, Crystal, & Thomas, 1977; Rehm, 1971; Sheppard, 1971). Misconceptions about older workers' abilities, limited program funding, and an attitude that services should be given first to those clients with a longer term of productive years ahead are common barriers to the elderly (Birren, 1964; Hiemstra, 1972; Palmore, 1976; Rasch, Crystal, & Thomas, 1977). Schools are beginning to be more responsible to the educational needs of the aged, however, their

programs are frequently oriented more towards recreation than vocational development. The employment and educational needs of older persons are predicted to continue increasing and social service agencies will also become more involved in these concerns (Donahue, 1953; O'Dell, 1957; Vontress, 1970). Thus, it is important that employees of these agencies become better informed about the needs and capabilities of the elderly in terms of work and school. Counselors can play a very vital role in facilitating older persons' access to the employment and educational services, and in dispelling the negative images and attitudes of social service and rehabilitation workers towards older persons' intellectual and vocational potentials (Buckley, 1972; Grawbowski, 1972; Griswold, 1971; Vontress, 1970).

Health Needs and Characteristics

Despite commonly held misconceptions, old age is not a disease state and does not produce any one identifiable debilitating condition. The health problems of older persons are chronic, complex, and frequently are not significantly improved with treatment. Although geriatric research has produced some remarkable insights, the causes of most degenerative changes associated with age remain unknown (Busse & Pfeiffer, 1976; Fact, 1978; H.E.W., 1974). This situation further compounds attempts at medical care and frequently results in a regimen consisting of treatment of symptoms only and maintenance of the status quo (H.E.W., 1974).

The importance of physical health (or its decline) to older persons cannot be over-emphasized. As one source states, ". . . health has a greater influence on a person's concept of himself than does age

and personality changes and the psychological effects attributed to aging are in large measure reactions to health states rather than to chronologically determined processes alone" (H.E.W., 1974, p. 1). In this area, the common belief that older persons are very concerned with their health is more realistic than not. In truth, the incidence of ongoing, debilitating, and disabling conditions does increase with age and these illnesses do restrict older persons' mobility, sensory acuity, and general feelings of well-being (H.E.W., 1978). These changes in health and physical functioning which characterize older persons can result in development of several areas of problems and needs.

Health concerns of older persons living on reduced incomes can lead to their dependence on public agencies and subsidized medical care. In some cases, older persons may go without needed medical attention because of lack of money, ignorance of available services, or reluctance to become dependent on agency assistance (Bellak, 1976). These problems are compounded by the attitudes of social workers and health practitioners towards elderly clients and patients. Thus, despite increased need for medical services among the aged, medical providers are sometimes reluctant to give them adequate or appropriate attention (Bellak, 1976; H.E.W., 1974; H.E.W., 1978).

The origins of negative attitudes among allied medical professionals towards the health needs of older persons are complex and are discussed more fully in succeeding sections. At this point, it is relevant to note that dispelling these misconceptions is difficult, but is an area in which counselors may be helpful and must be knowledgeable (Bellak, 1976; Bennett, 1976; Buckley, 1972). Other considerations in terms of health related needs include the impact on

mature families who must deal with an older parent's or spouse's declining health and the dilemma of increased life span coupled with physical limitation.

Living Arrangements

The living patterns of older persons constitute an area of significant change and need. Although a prevailing image of older persons suggests that most of them are frail, incapacitated residents of old age centers and nursing homes, in reality only a small percentage (approximately 5%) are in such institutions (H.E.W., 1978). Of those so confined, it is estimated that a considerable number could be capable of independent or semi-independent living if adequate supportive services were readily available. A detailed discussion of the cost and inadequacies of institutional care for the elderly is beyond the scope of this review. Yet, counselors need to be aware of these factors and can make a valuable contribution towards meeting the specialized needs of nursing home residents (Manney, 1975; Montgomery, 1972; Pressey & Pressey, 1972).

Alternative living arrangements for older persons are available which reflect their housing needs. Housing complexes and government subsidized residences make affordable housing accessible to older persons on limited incomes. Such complexes can also meet the personal security needs of older persons as well as be accessible to the physically frail and handicapped resident. This type of age-restricted housing can bring into focus the social and activity needs of the elderly and many such projects do have staff and programming for these needs. Thus, the age restricted housing setting is another area in

which counselors can direct their efforts toward providing individual, group, and consultant services (Boyd & Oakes, 1973; Stevens, 1972).

Non-government housing for older persons frequently takes the form of age-segregated subdivisions, apartments, and restricted "adult" communities. These developments do meet the needs and the residential preferences of a large number of older persons for whom such arrangements are economically feasible. As with subsidized housing, residents of these projects could also benefit from counseling services (Fact, 1978; Stevens, 1972).

A noticeable trend among older persons is that an increasing number of them are living alone. One source notes that in the past 16 years, the number of lone older persons has grown three times faster than would be estimated from overall population growth. Further, the proportion of non-institutionalized elderly living alone has increased from one-sixth (1960) to one-fourth (1976) (H.E.W., 1978). The largest increases in single-person households are among women and the "old old" subgroups (H.E.W., 1978). Should this trend continue, then the demands for social service programs to meet the special needs of lone older persons can also be expected to increase. The need for home services is particularly evident in light of the intent and focus of aging legislation that mandates maintenance of independent living in the community for the elderly (Florida, 1978a). In terms of perceptions and attitudes, the notions that most older persons require great amounts of care, need to be institutionalized, or are incapable of self-maintenance need modification (Bellak, 1976; Butler, 1975; Frankfather, 1977).

Attention should also be drawn to the living arrangements of widows, particularly because these older women constitute a substantial number of those who reside alone. Several factors give rise to the special needs and problems of older women and widows. Separation of families through geographic mobility has contributed to the decline of multi-generational families living together and thus to widows' isolation (Field, 1972; H.E.W., 1978; Kent, 1972). The majority do not remarry and so continue to live alone on limited incomes (H.E.W., 1978). Social services have only recently focused on the needs of this group and projects such as the Displaced Homemaker programs have helped to solve some of the problems of these persons (Florida, 1978b). Counselor contributions to the situations faced by widows and widowers have been noted by several authors (Buckley, 1972; Jackson, 1977; Kalish, 1971,; Moberg, 1972).

Social, Activity, Family Needs

The changes in lifestyle which can accompany retirement have been noted previously. There are additional implications in terms of the social and activity needs of older persons and the changes that characterize the mature family. Previous generations included more defined, viable roles for older persons within an extended family system. The current trend towards maintenance of an isolated, nuclear family has largely negated these roles (Berardo, 1972; Jackson, 1977; Shanas, 1972, 1969). However, inter-generational contact is maintained today and patterns of kinship assistance and communication are important sources of emotional and other support for older persons (Duvall, 1962; Leach, 1964; Reiss, 1969; Rosenmayer, 1968). Although

many older people reside alone ". . .almost no one is without some kind of contact with other members of his family" (Thompson & Streib, 1961, p. 179). Indeed, some sources predict a resurgence of multi-generational families, and renewed importance for the grandparent role. These changes are partially attributed to the longer life span and the economic dependence of more older persons on their adult children (Hader, 1965; H.E.W., 1978; Tartler, 1963; Streib, 1965).

Another event characterizing adult family changes is the re-marriage of older parents. Such a decision can lead to considerable family problems and may meet with significant resistance from the adult children. Whether the late marriage is between two older persons or one younger or one older, opposition to these matches is indicative of several commonly held prejudices and stereotypes about older persons. It is believed by some that older persons' continual interest in and need for marital closeness and sexual relationships are unnatural at worst and not normal at best (Streib, 1965; Sussman, 1972; Sweetser, 1963). This is an area in which marital and family counseling services can be of significant benefit to both older parents and their adult children as they cope with the realities of older persons' needs (Bock, 1972; McKain, 1969).

The problems and needs older persons encounter when facing death and dying have received considerable attention in the literature of recent years. The loss of a spouse or older parent requires adjustments that affect most areas of an older person's life. The grief process has been defined and the role of counseling in facilitating it has been well described (Altameir, 1957; Buckley, 1972; Jackson, 1977; O'Dell, 1976; Pfeiffer, 1976; Pressey, 1973; Salisbury, 1974).

Wass (1979) indicated that while one man in six, age 65 or over is widowed, women have much more prominent marital bereavement problems. By 65 years of age, 50% of women have lost their husbands and by 75 years of age two-thirds have experienced loss of spouse. These data support the contention that older persons are survivors.

In addition to the loss of spouse, older persons must also cope with the loss of relatives, friends, and acquaintances, many of whom may be younger. Older persons may experience "bereavement overload," that is, the phenomenon of not having enough time to deal with the grieving of one loss before others occur. As stated, "only recently have we learned that grieving takes much longer than was believed and that among the grief reactions we find are psychological and physical illness and even death. Grief, then, may be a constant companion in old age" (Wass, 1979, p. 200).

Connected with bereavement changes is the tendency for many older persons to experience what has been termed the life review (Butler, 1975). Further, life review therapy has been recommended as an effective means for counseling older persons. This kind of therapy does not require a psychotherapist, nor is an office or medical setting necessary. It can be carried out in the home, at recreation centers, in the home of the older person, or in a nursing home. The counselor must possess basic skills in active listening, must have a great deal of empathy, and should have a basic knowledge of the process of aging. However, grief counseling can be provided by persons with relatively little formal training. Volunteer programs have proven successful in reducing negative feelings brought on by grieving (Wass, 1979).

The life review and related reminiscing activities may contribute to the stereotyped views that older persons are entering a second childhood, that they are incapable of coping with the present, and, therefore, that they prefer to retreat into past memories. Again, informed counselors can both facilitate this psychological process and help dispel erroneous interpretations of it.

Increased amounts of leisure time available to older persons who are no longer employed constitute a marked change from their earlier years. Recreation, leisure activities, and volunteerism have been commonly sought avenues of meaningfully using this time (Harper & Garza, 1969; Messer, 1968; Stickle, 1977). The increased free time for retired older persons can produce boredom, feelings of uselessness, inactivity and isolation. The elderly have a particular need at these times for continued involvement and stimulation. Stereotyped perceptions of older persons as incapable of learning further restrict their access to needed programs and activities (Butler, 1975; Carp, 1972; Fact, 1978; Frankfather, 1977; Kilty & Feld, 1976). Social service agencies and workers may tend to place little importance on the social and recreational needs of their older clients, and not realize the potential spin-off benefits active involvement can bring to older persons. These benefits can also be realized for the elderly who reside in nursing homes and institutions. Again, this is an area of need which can effectively be addressed by counselors (Miller, Lowenstein & Winston, 1976; Salisbury, 1974; Stevens, 1973; Vontress, 1975).

Perceptions and Attitudes Towards Aging

The preceding discussion of characteristics of older persons has emphasized the origins from which several commonly held erroneous perceptions and negative attitudes towards the elderly derive. The existence of such stereotyped views of the elderly can influence the quality of social service programs provided for them. As one author notes, ". . . how aging and the aged are viewed is a vital factor in determining the policy set for aging services by program developers" (Vasey, 1975, p. 5). Although virtually no research has been done on attitudes towards counseling services for older persons, there has been substantial investigation into attitudes towards aging. Some of this work has focused on the perceptions of program administrators, direct service providers, and trainees in the allied helping professions. This section will review these studies, the types of instruments used, factors that have been identified as influencing attitudes towards older persons, and the effects of such perceptions on service delivery.

Attitudes have been defined as ". . .ideas, opinions, beliefs, sets, prejudices, values, etc., that are acquired through learning and that predispose one to react in a certain manner to other ideas, persons, objects, etc." (Hopke, 1968, p. 35). That negative attitudes towards aging and older persons are not uncommon is evidenced by the coining of terms such as "ageism" and "gerontophobia" to describe these disparaging perceptions. Counselors need to be concerned about such attitudes and the impact they have on services for, as has been stated, ". . .one of the main sources of stress that the elderly face are the many negative stereotypes or prejudices against them that most people in our society share" (Palmore, 1976, p. 37).

Areas of Research on Attitudes Towards Aging and the Aged; Instruments

Investigators into attitudes towards older persons and towards aging have concentrated their studies on several main categories of subjects. A considerable number of studies have been done using students of varying ages and college trainees enrolled in health oriented curricula. Similarly, pioneer researchers in these areas developed the most frequently used instruments using student age subjects (Ivester & King, 1977). Such studies as these tend to concentrate on correlations of attitudes towards the aged and characteristics of the respondents in terms of the subjects' own age, educational level, and amount of contact with older persons. This approach to attitude research has been considered deficient in its omission of other correlating factors such as characteristics of different groups of older persons (those who live independently versus the institutionalized, for example) (Keith, 1977).

Another category of research into attitudes towards aging identifies three major areas of investigation (Mutschler, 1971). First are the measures of attitudes towards aging and the aging process as perceived by subjects of various ages. This approach also includes those studies dealing with attitudes of older persons themselves toward growing older. The early works of Tuckman, Lorge, and Kogan are representative of this aspect. Second, measures of psychological characteristics of individuals are studied which may be relevant to their attitudes towards older persons. This area also includes studies which assess characteristics of subjects that correlate with choice of work with older persons. The third area deals with research into the

adjustments made by older persons to growing older. Studies using instruments such as the Life Satisfaction Rating Scale fall into this area.

Research in these areas has generally relied on relatively few questionnaire and survey instruments that have been modified or adapted to different subject groups and purposes. Early investigators developed questionnaires utilizing semantic differentials, Likert and other types of rating scales, and most recent studies have relied on these or modifications of these instruments (Burdman, 1974; Colgan, 1976; Eisdorfer & Altrocchi, 1961; Garfinkel, 1975; Ivester & King, 1977; Keith, 1977; Mutschler, 1971; Rasch, Crystal & Thomas, 1977; Ross & Freitag, 1976; Walter, 1976).

The early works of Tuckman & Lorge resulted in the development of the frequently used Attitudes Towards Old People Scale. Based on studies using graduate students in the early 1950's, this questionnaire probes 13 areas relating to physical, sensory, financial, conservatism and other factors influencing misconceptions and stereotypes about aging and older persons (Tuckman & Lorge, 1953). These two researchers have also developed an Older Workers Questionnaire; however, it is not as widely used (Mutschler, 1971). Kogan has developed another frequently used instrument similarly titled the Attitudes Towards Old People Scale. This is a 34 item Likert type scale studying areas of commonly held stereotypes towards aging (Ivester & King, 1977; Kogan, 1961). Golde & Kogan (1959) have also developed a sentence completion procedure for assessing attitudes towards older persons. Rosencranz & McNevin developed, in 1969, an Aging Semantic Differential which has been used to clarify several dimensions of attitudes towards aging

including dependency, instrumentality, and accredibiltiy (Rasch, Crystal & Thomas, 1977; Ross & Freitag, 1976; Walter, 1976).

In addition to these most frequently used instruments, several others have been developed to study different aspects of attitudes and adjustments towards aging. Oberleder's Attitudes Toward Aging Scale (1961) has received some use (Garfinkel, 1975). Sroles developed an instrument in 1956 to assess factors related to choice of work with the aged (Mutschler, 1971). Several instruments have been created to study satisfaction, adjustment, and emotional well-being of older persons. Notable among these are the Maddox Morale Scale (1963), Neugarten & Associates' Life Satisfaction Rating Scale (1963), Lowenthal's Measurement of Interaction (1965), and Kastenbaum's Hospital Questionnaire (1967) (Mutschler, 1971).

Of the few studies devoted to research on attitudes of program administrators and others who determine policy towards services for older persons, several of the above mentioned instruments have been utilized. Oberleder's Attitudes Towards Aging Scale has been used in studies involving psychiatrists and clinic directors (Garfinkel, 1975). However, several of the most informative studies using this category of subjects have relied on instruments developed by the researchers or modifications of existing scales. Keith's study of stereotypes about older persons among administrators used an eight item, five point Likert scale developed by the author (Keith, 1977). A particularly comprehensive study of administrators, planners, and legislators used a series of information seeking questions rather than the types of scales discussed above (Kasschau, 1976). Similarly, Vasey (1975) conducted his inquiries into attitudes of aging program policy makers

using a questionnaire format which he developed. The works of these authors suggest that the traditional instruments used to assess attitudes towards aging and older persons may be inadequate to determine perceptions by subjects such as administrators and direct service providers towards services for the elderly. Although the tools available to measure perceptions and attitudes towards aging appear sufficient, it would seem necessary and justified to create a new instrument to investigate social service personnel attitudes towards counseling services for older persons. The rating scale and questionnaire type formats appears most frequently used and appropriate for this new area of inquiry.

Attitudes Towards Aging Among Trainees, Practitioners and Administrators

A closer examination of several studies into the attitudes of student trainees, social service and health practitioners, and policy makers and administrators is helpful for several reasons. Although these studies do not focus specifically on counseling services for older persons, there are some commonalities and a number of the authors noted the need for the contributions counselors can make. Second, the subjects of these studies will enter or are currently engaged in health and social service programs for older persons and their attitudes towards their clients and their work are crucial to the successful provision of services. Many such personnel are the ones with whom older persons must deal directly and with whom counselors can work to improve understanding and acceptance of their older clients.

A number of studies have looked at the attitudes of various groups and ages of students. This review will concentrate mainly on those dealing with perceptions of college and graduate students because these findings seem to be more pertinent than those involving much younger subjects. Bennett has reviewed a number of studies of younger persons' attitudes towards the elderly. She notes that, overall, the results have indicated that training and/or contact with older persons tends to reduce or develop less negative attitudes, although such improvements are not always significant or lasting. She concludes by advising that, in terms of attitudes, "A concerted effort should be made to stop perpetrating the view of the aged as 'them' and the young as 'us'. Everyone ages. The aged are not an exotic minority group towards whom some people can feel detached but sympathetic" (Bennett, 1976, p. 137).

Burdman's study of student and trainee attitudes noted a ". . .void in terms of reciprocal professional understanding" between students in gerontology and rehabilitation counseling (Burdman, 1974, p. 66). This lack of mutual understanding further compounds the problems generated by the subjects' negative views of older persons (Burdman, 1974). Colgan noted that attitudes toward older persons improved slightly with participation by students in a gerontology course(Colgan, 1976). Ivester & King also reviewed research involving older adolescents' perceptions of older persons. They noted a ". . .tendency for all age groups to view the aged as possessing stereotyped traits and this tendency becomes stronger with increasing age" (Ivester & King, 1977, p. 88). Rasch and associates have also studied trainees' perceptions of older persons. Using the Aging Semantic

Differential, they assessed rehabilitation counseling students' attitudes towards both able and disabled older persons. Results indicated a tendency to view older persons as less feasible for rehabilitation services than younger handicapped clients. These findings are particularly noteworthy in view of other research which the authors state ". . .clearly demonstrated the abilities of older disabled workers to profit from vocational rehabilitation services" (Rasch, et al., 1977, p. 126). The authors' conclusions from this study are particularly relevant in view of the existence of rehabilitation counseling and similar service programs within the Florida HRS system. As they state ". . .this apparent contradiction between counselor opinions and objective research suggests the possibility of biased attitudes towards the old among rehabilitation personnel." And, further, they note, "Although the aging stereotype is one of the most extensively investigated issues in gerontology, it is only recently that a major focus of this research concerned the attitudes of human service professionals" (Rasch, et al., 1977, p. 124).

Ross & Freitag have compared adolescent and adult attitudes toward the aged and also noted that such perceptions improve with age and with contact with older persons (Ross & Freitag, 1976). Seltzer & Atchley reviewed literature for young persons to evaluate the presence therein of stereotyped views of aging and older persons. They noted a consistent tendency towards negative portrayals of older persons (Seltzer & Atchley, 1971). As noted previously, Tuckman & Lorge's original studies involved graduate student subjects and determined the existence of substantial misconceptions of older persons (Tuckman & Lorge, 1953). In an unpublished study, Walter compared

attitudes of undergraduates in social work and in non-related fields towards the elderly. His results indicated that graduating social work students held more positive attitudes than did either beginning social work students or students in other fields (Walter, 1976).

Research into attitudes of social service providers and practitioners has dealt mainly with social workers, mental health personnel, nurses and physicians. Studies of this type have been made more difficult because of the dynamics of the influence of the subjects' own fears and attitudes about aging as well as their opinions about older persons. The investigations into physicians' attitudes perhaps best illustrates this situation for their professional competencies (the need to "cure" and to preserve life) have been noted as contributors to their negative views of aging. As one author notes, "If the goal of medicine is seen as victory over death, then those patients who because of age are closest to death are bound to be viewed negatively" (Bellak, 1976, p. 17). This author further points out the threats to a physician's sense of control, authority, and competence in the relationship he has with older patients and the effects these conditions have on doctors' perceptions of the elderly. Physicians may misinterpret the older patients' own attitudes and motivations as self-pity, dependency, or stubbornness, all of which further intrude upon an open, communicative relationship (Bellak, 1976).

Negative views of older persons among medical personnel are reinforced, perhaps unavoidably, because they rarely see the majority of older persons who are relatively healthy and not institutionalized (Palmore, 1976). As Palmore states ". . .this bias may lead to the belief that illness and senility are natural and inevitable among

the aged, that nothing can be done about it, and that the little that can be done is hardly worth doing" (Palmore, 1976, p. 37). The potential for a circular type of self-fulfilling prophecy to develop from these attitudes is apparent, and similar circumstances have been noted with other health and social service providers working with the aged. Other sources have also noted the tendency among physicians to disregard symptoms presented by older patients as being either untreatable or simply due to the uncertainties of aging (Bellak, 1976; Boyd & Oakes, 1973; Pfeiffer, 1976).

The attitudes of mental health workers towards the elderly have also been extensively investigated. As Pfeiffer notes, ". . .there is evidence that prejudices against the elderly are not confined to lay society, but also are present among the health professions" (Pfeiffer, 1976, p. 192). As with the physicians studied, mental health workers' attitudes are also affected by their personal fears of aging, and older persons frequently embody these fears. Butler has also noted the influence of what is termed the YAVIS syndrome, that is, the preference for mental health personnel to work with patients who are young, attractive, verbal, intelligent, and successful (Butler, 1975). To spend time with older clients is frequently perceived as the opposite of this situation and thus is deemed non-productive both in terms of client progress and monetary payments (Fact, 1978; Mutschler, 1971). It has been estimated that approximately three million or over 13% of the older population need immediate mental health services. Another seven million are described as living in conditions conducive to the development of mental illness. Should this present trend continue, it

is projected that, by 1980, approximately 80% of those who need them will not get mental health services (Fact, 1978).

The mental health needs of older persons are not substantially different from those of other age groups but reflect the difficulties encountered in any period of marked change and adjustments (Boyd & Oakes, 1973; Buckley, 1972). As one source notes, "Most elderly diagnosed as having fundamental disturbances can be helped . . . most of the difficulties that arise are treatable with minor counseling or intervention" (Fact, 1978, p. 167). Yet, despite the substantial numbers of older persons needing mental health services and the relative simplicity of their treatment, the older population receives an estimated less than 2% of private psychiatric time and about 2.3% of total outpatient psychiatric services (Fact, 1978). Older persons are in need of supportive, informational, and empathetic counseling relationships, yet these kinds of mental health services are frequently denied them by the attitudes of professionals in the field (Butler, 1976; Eisdorfer & Altrocchi, 1961; Fact, 1978; Frankfather, 1977; Garfinkel, 1975; Mutschler, 1971). Garfinkel found agreement among her subjects with the notion that older persons are not inclined to be verbally active in a relationship. This attitude, she notes, leads the therapist to assume that working with older persons will not be productive. Since such patients won't "talk" they can be more or less legitimately avoided. As Garfinkel states, "The irony of this attitude is that it affects the population most likely to benefit from the supportive, accepting, therapeutic relationship" which could sustain older persons through the loneliness, depression, and lowered self-esteem that characterize the various losses occurring in late life (Garfinkel, 1975, p. 136).

Compounding the problem of negative attitudes toward the elderly and misconceptions about their potential to benefit from treatment is the relative paucity of theory and practice in the realm of psychiatric and mental health techniques for working with this group. It is noted that practitioners may avoid the older client partially because they are ignorant of appropriate methods for use with them (Bellak, 1976; Fact, 1978; Mutschler, 1971). On the other hand, although counseling with older persons is a relatively new specialty, most sources suggest that existing techniques and approaches should be adequate to deal with the majority of the older clients' problems. The tendency for mental health workers to overlook or de-emphasize the physical and psychological causes and influences on older persons' mental health status can lead to erroneous diagnoses and nonproductive treatment (Boyd & Oakes, 1973; Fact, 1978; Mutschler, 1971). Many practitioners, not unlike most laymen, assume ". . .that mental or emotional difficulties are an inevitable product of old age. . .these negative attitudes can severely limit access to care and, if access is achieved, limit the appropriateness of the care received" (Fact, 1978, pp. 166-167).

Thus, it can be seen that older persons have generally not received adequate mental health services, despite demonstrated needs and responsiveness to treatment. Attitudinal resistance to working with this group is partly responsible, and apparently much more gerontological education is needed for mental health practitioners. Persistence of stereotyped, negative perceptions has important implications for this study. As will be discussed later, funds and programs to provide counseling services for older persons currently are located mainly in mental health centers. Thus, the attitudes of these providers towards both older

persons and towards the efficacy of counseling services for them are crucial.

The attitudes of other groups of direct service providers towards the elderly have also been studied. The general category of social worker will be taken to include those personnel whose functions include provision of a variety of outreach and social services aimed at meeting the health, housing, financial, and other needs of older persons. Generally, those are the workers who have the most direct, frequent, and personal contact with older persons and who are most likely to be aware of their environmental needs and conditions. In many cases, they are representative of a larger bureaucracy and the link between the older person and various levels of governmental agencies. Obviously, then, the attitudes of direct service providers are important to the successful provision of assistance to older clients (Pfeiffer, 1976).

Attitudes of direct service social workers have been investigated by several authors. One study provides examples of comments made by social workers about their elderly clients and these comments are enlightening. As this author notes, "These workers experience conflict between their traditional roles and direct services. The worse off the client, the less likely he is to get help. No one wants the job of direct services" (Frankfather, 1977, p. 40). Several comments of the subjects in this study suggest the difficulty of their assignments and the necessity for more personnel to do this level of work. As one states, "But who's going to do the work? Who do you send in when feces are smeared all over the house? You have to be tough. We do direct services even though we're not supposed to. We do it because

that's what's needed" (Frankfather, 1977, p. 41). These duties are contrasted with the geriatric social workers' traditional role of arranging and coordinating services; the resulting differences between training and practice are contributive to negative views of older clients. Another geriatric social worker commented, "You have schizophrenics and depressed old people who need therapy. They also have very concrete needs--money, housing, food--as well as complex personal problems. You don't separate one from the other. There aren't services to handle both, so you do it" (Frankfather, 1977, p. 40).

These comments are instructive, for they emphasize several points relative to the development of stereotyped views of older persons and the resulting lowered quality of services provided them. The necessity for meeting the basic human needs of the elderly is apparent and these must be satisfied prior to or simultaneous with provision of counseling services. That professionally trained social workers must provide direct custodial services to older persons is, as reported by Frankfather, believed to be wasteful of their expertise, and not likely to make them over-fond of such clients. Social workers in consultation with gerontological counselors might enhance both their abilities to deal with these realities and their attitudes towards the aged clients.

In another study, factors were reviewed which influence the choices and perserverence of work with the aged among social workers. These factors, which tended to focus on the negative aspects of older persons, included the low status of older persons in contemporary society, the lack of research and theoretical background for clinical practice, and stereotyped concepts of adequate clinical techniqeus with which to serve

older clients (Mutschler, 1971). It is suggested that these same factors could be influential in determining the choice of other professionals to work with older persons. Counselors could be useful in reducing or eliminating some of these influences and in providing overall leadership for enhancing the attitudes of all social service providers towards older clients. As Mutschler notes, "Thus, the low ranking of both the client group and the therapeutic techniques associated with it by fellow professionals deter social workers, psychologists, etc. from entering the field" (Mutschler, 1971, p. 235). In addition to the above mentioned influences, this study revealed a stereotyped view of older persons as rigid and incapable of growth and insight. This attitude increased the professional's reluctance to enter or remain in gerontological service. It was further noted that the underlying fears of death and aging held by the subjects further contributed to the reluctance to work with older persons or to view services for them as beneficial (Mutschler, 1971). The implications of this type of study suggest that workers' attitudes towards clients influence both the quality of care they offer and the type of services believed to be appropriate. Thus, social workers may believe that counseling services for older persons may be of little use because the elderly lack the ability to benefit from them or because the social workers themselves are unaware that counseling techniques suitable for this type of work are available.

Although the majority of research has focused on attitudes of medical, social work, and mental health personnel, several studies deal with the perceptions of administrators and planners towards older persons. It is apparent that more study is needed with these groups

because their decisions are crucial to the development of program policy and implementation and, in the case of institutional administrators, for the kind and quality of services provided. A particularly comprehensive study by Kasschau (1976) investigated the attitudes and opinions of a large sample of agency, business, and governmental planners and administrators who dealt with the income, housing, transportation, employment and other needs of the elderly. Legislators who voted on relevant bills or served on such committees concerned with aging needs were also surveyed. These subjects were chosen in part because "the extent to which the elderly are able to participate in the food stamp program or able to find housing in the Model Cities Program is often largely the function of the discretionary decision making powers of these top-level administrative agency officials" (Kasschau, 1976, p. 16). Results of the study indicated the existence of a number of stereotyped views of the elderly. However, most planners believed that programs and services were needed for older persons. The deficiencies of social services systems were generally felt to be the result of the attitudes and actions of the social workers and other direct care providers. The subjects were also concerned over the increasing amounts of free time available to older persons. Even so, they frequently failed to consider leisure activities in program planning or the positive effects of such activities on the health of older persons or their abilities to effectively use this time. In summary, it would seem that high level administrators and policy makers are concerned but inadequately aware of the needs and characteristics of older persons and of the logistical difficulties faced by direct service providers. Further, it was noted that such subjects could profit from the input of older persons themselves in developing programs.

A diversity of programming and opportunities for the older person to become active in the community was noted as was the need for more systematized services (Kasschau, 1976).

Another study investigated attitudes of nursing home administrators towards older persons and services for them. Some relationship between attitudes and level of subjects' education was demonstrated but stronger influences were shown between age, sex, and socio-economic levels of older residents. As the author notes, "the age of clients alone or in combination with the effects of other status characteristics, may also influence professional recommendations for their care or even career decisions to work with the aged" (Keith, 1977, p. 465). Thus, it is suggested that attitudes of administrators can be as influential on service provision as those of direct care workers. As another author puts it, "We now realize the importance of a positive attitude toward care and rehabilitation of the aged. In a good nursing home a philosophy of care projected from the administrator through all levels of staff is evident" (Ernst & Shore, 1975, p. 5).

Another paper reviews the factors influencing both policy makers and the public which through their taxes must support programs for older persons. These factors include how aging and the aged are viewed and the level of confidence held by the public and policy makers in the efficacy of programs and services (Vasey, 1975). Vasey states the problem well:

> If we do not like or approve of the people who are being served, we are not likely to support services developed on their behalf. . . . We are inclined to be detrimentally influenced by negative views of the aging process. If we think they are suffering from an irreversible decline of mental and physical faculties, we are not likely to feel committed to

> spending money to provide measures of treatment or restoration. Our policies will be more likely to reflect a preference for residual programs of care and custody. If we believe they are too old to learn, we will probably not want to do much about educational programs designed for them. Let me emphatically suggest that research and experience which demolish these myths and erase the false stereotypes that have grown up around aging and elderly can have a profound effect on the conditions of life for older people and a telling impact on public policy. (Vasey, 1975, p. 29)

This statement succinctly summarizes the prevailing theme of this literature review, that attitudes can and do influence program planning and service delivery for older persons. Although not specifically addressed in the literature, it seems logical to assume that counseling services for older persons may be viewed in a similar light.

In summary, it is suggested that a relationship exists between misconceptions about the needs and characteristics of older persons and the quality and type of social services provided them. In addition to the negative attitudes held by workers at all levels, the fears of aging and death represented by older persons serve as strong influences on their mode of dealing with the elderly and of the choice to work with them. That there is a strong need for counseling and a viable role for counselors' leadership in interrupting this cycle of negative attitudes and poor services is evident. This need is an immediate one and can be expected to increase in the near future. The next section will review the extent to which programs currently address the counseling needs of older persons in Florida.

Organization and Funding of Counseling Services For Older Persons

As has been indicated, the attitudes of both professionals and the public can influence the quality of social services provided to older persons. Several sources have commented on the form or organization through which these services are delivered to older persons. In general, it is noted that service programs for today's older persons lack planning and direction focused on realistically meeting their needs. This section will discuss the criticisms and suggestions offered concerning service programs for older persons; the major funding sources; and organizational structure as it relates to provision of counseling services.

A recurrent theme found in discussions of service delivery for older persons relates to the need for a comprehensive, multi-disciplinary approach to meeting their needs. As one source states, "If an elderly patient has a problem in one area, it is extremely likely that he will have problems in other areas as well" (Pfeiffer, 1976, p. 193). This author further notes that the existence of multiple problems among older persons is frequently compounded because they lack the means or the resources to reach the different locations where these needs can be met. The role of a service coordinator is suggested as one who could facilitate such travel for older persons when a central facility is unavailable (Pfeiffer, 1976).

The concept of the community care center has been suggested as a way to meet the various social, recreational, and emotional needs of older persons (Boyd & Oakes, 1973; Burdman, 1974; Sylvester, 1976). Coupling these services with nutrition programs has already

been implemented with considerable success in many areas. Such centers, however, do not generally provide screenings nor do they administer social service programs. Counseling services could be logically included in this type of setting or as a base for conducting outreach counseling (Sylvester, 1976). Boyd & Oakes further note that the concept of comprehensive services depends on a recognition that, for many older persons, economic and social needs are as pressing as medical ones. The organizational barriers encountered by the elderly are noted as more formidable when seeking these kinds of services. As is stated, "Likewise, a person with an emotional problem or psychiatric illness should receive aid or appropriate help as soon as possible without having to go through all sorts of unnecessary channels" (Boyd & Oakes, 1973, p. 140). These authors suggest a central service agency for older persons which includes an information and referral service, diagnostic center, and a "well-aging" clinic. The emphasis in this approach would be on prevention, particularly with regard to mental health concerns (Boyd & Oakes, 1973).

In summary, those authors who have investigated attitudes towards aging and older persons tend to note the need for a comprehensive center for services designed to meet multiple needs. The bureaucratic barriers imposed by governmentally funded and/or administered programs are also cited as hindrances in meeting these needs. The need for an advocate, a guide, or a coordinator to lead older persons through existing agencies is noted. As one source states, "The general complaint is that professionals treat their clients more as items to be processed than as people to be served" (Manney, 1975, p. 101). It is acknowledged that the dehumanizing treatment of social service

recipients is not solely aimed at the elderly; however, the negative view with which older persons are seen is believed to further strengthen this tendency. Providing professionals and social service workers with greater knowledge about older persons will not automatically reduce negative attitudes or improve services. As Mower notes, "Understanding aging processes does not necessarily guarantee that one will approach an older person in a different manner. However, through this understanding, positive behavior of staff members may be encouraged while negative behavior, which actually impedes the independence of the aged, may be reduced" (Mower & Shore, 1975, p. 3).

The literature seems to emphasize that comprehensive services for older persons are needed and that negative attitudes towards the aged can limit the effectiveness of existing programs and the development of new ones. As Butler has noted, "We know what services older people need and that these needs are extensive. The financing and logistical problems are not insoluble. Now, however, services of all kinds for old people are fragmented, limited, discriminatory, inaccessible or non-existent. When services are available, their quality is questionable" (Butler, 1975, p. 140). This comment suggests it is necessary and helpful for counselors concerned with older persons to become familiar with the legislation, sources of funding, and organization of service programs for older persons.

The Older Americans Act of 1965, with its subsequent amendments and revisions, is the initial legislative action that established the majority of nationwide aging programs and services. The Act delineates four national priorities for services towards which the majority of funds and efforts should be directed. The language of the Act, however,

does not rate any one of these four areas of need ahead of another; housing, transportation, homemaker, and legal and other counseling services are given equal stature in the Act (H.E.W., 1975). Additionally, the Act does not specifically require that each of the four areas of need be addressed equally. State governments are only required to "provide for the establishment or maintenance of programs [including related training] for the provision of some or all, of the following services" (H.E.W., 1975, p. 25). Thus, it can be seen that state and local governments could concentrate their efforts solely on one or more services to the exclusion of the others, and still be in technical compliance with the Act. Additionally, the wording of the Act further presents a problem with respect to counseling services. Personal counseling services are included in a statement that seems to emphasize legal counseling.

It appears that the Older Americans Act makes it possible for programs to be developed which may meet some but not all needs of older persons. This is precisely the kind of fragmented, incomplete service program which was criticized by previously reviewed authors. The result of this wording has led to varied interpretations of the intent of the legislation. Apparently many states, including Florida, were considered to be providing inadequate attention to all priority areas. A directive from the Administration on Aging recently sought to clarify this portion of the 1965 Act. As is stated, "Despite the interpretation of the term 'some' the legislative history indicates that Congress intended all four services to receive priority attention" (H.E.W., 1977a, p. 140). It is of interest to note that an earlier instruction from the Administration on Aging recommended that the states

focus on the national priorities for service, but that counseling services were not listed among them. The statement, "legal and other counseling services," was reduced to legal services only (H.E.W., 1977).

Those concerned with counseling services for older persons need to be aware of these legislative provisions and their interpretation. Attention should be directed towards insuring that the full range of counseling services receives an equal share of funding and program development by the states.

To assist in the effort to meet the counseling needs of older persons, a legislative bill was developed in 1977 aimed at providing adequate counseling services for the elderly. This proposal, (HR1118: Guidance and Counseling for the Elderly) outlines a comprehensive counseling program for older persons. Counseling in this instance was defined as "the process through which a trained counselor assists an individual or group to make satisfying and responsible decisions concerning personal, educational, social, and vocational development" (U.S., 1977, p. 36). Inclusion of this or a similar definition in the portion of the Older Americans Act dealing with the priority services would have perhaps given counseling a clearer identity and stronger position relative to other priority services. Regretfully, this bill has not been passed.

Federal funds for Older Americans Act programs are provided to the various states through a central state administration. Each state develops a state plan on aging which describes the goals and methods by which needs are met and services are provided. In Florida, the state plan is prepared by the Department of Health and Rehabilitative

Services which was re-organized in 1975. The purpose of this change was to "integrate the delivery of all health, social, and rehabilitative services offered by the state to those citizens in need of assistance" (Florida, 1978a, p. 112). Thus, the intent was to provide the type of comprehensive service delivery system that previously mentioned authors felt was best suited for meeting the needs of older persons. The success of this re-organization has not been thoroughly evaluated. However, the shift did lead to the establishment of a separate office of Aging and Adult Services, which has the major responsibility for administration of all aging programs.

The current (1978-79) Florida State Plan on Aging outlines several overall objectives. Of particular relevance to counseling is the statement that the State will develop program standards for a minimum of three social service programs funded under Older Americans Act auspices. Thus, more emphasis to a greater number of the priority services is anticipated (Florida, 1978c). More specific to counseling is the proposed objective to provide counseling services to a minimum of 23,538 older persons statewide. These services will include assistance with psychological, family, and social concerns to be "explored within the confines of a confidential relationship with trained professionals leading to an improved sense of mental well-being for the elderly persons" (Florida, 1978c, p. 28). It is apparent that a great deal more than legal advice is implied in this statement. The proposed priorities for Florida as outlined in the State Plan include efforts to reduce negative stereotypes and attitudes associated with aging and older persons (Florida, 1978c, p. ii). It is clear that the 1978-79 State

Plan for Florida gave increased attention to counseling needs and services.

The review of literature pertinent to this study has focused on the relationship between attitudes towards older persons and services provided for them. Areas of general need and characteristics commonly associated with older persons were discussed with emphasis on the probable origins of prevalent negative stereotypes about the elderly. Attitudes of various social service and health professionals were shown to be largely negative and to have an effect on the quality of care and services provided to older persons. Program planners and administrators' attitudes were also examined with attention to their roles in service deliery to the elderly.

Possible roles of counseling services in programs for older persons were reviewed and it was indicated such services should be given greater emphasis by both administrators and direct service providers. It is apparent that there is a need to assess the extent to which these predominantly negative impressions influence the attitudes held by workers towards counseling services for older persons. Although counseling has been established as a national and state priority, full implementation of this goal has not been achieved in Florida. If, as the literature suggests, negative attitudes influence service delivery, then it is important that this be established with respect to counseling. From this informational base, appropriate corrective plans can be developed to improve both attitudes and service to Florida's older population.

CHAPTER III

METHODOLOGY

The results of the literature review indicate that little has been done to develop counseling services as components of aging programs in Florida and in the nation. Of the four services given national priority, counseling has received the least emphasis in funding and programming in Florida (Florida, 1978a, c). The purpose of this study was to determine the perceptions towards counseling services for older persons held by selected employees of the Florida Health and Rehabilitative Services Aging and Adult Services Program Staff. The study also attempted to assess the relationship between the perceptions or attitudes held by Administrators and Direct Service Personnel toward services offered for older persons, and the relative importance given to counseling by Aging Program developers, administrators, and direct service personnel. This information may then serve as a baseline from which strategies and plans for funding and implementation of specialized counseling services for older persons may be made.

The research questions investigated by this study included:

1. How did the subjects define counseling and how did they differ in their definitions?
2. How did subjects perceive the role of counseling and of counselors in aging programs and how did they differ in their perceptions?

3. How did subjects perceive counseling in relation to other services provided in programs for older persons, and how did they differ in their perceptions?
4. How did subjects evaluate the current status of counseling services in aging projects and programs, and how did they differ in their evaluations?
5. How did subjects rate their own level of knowledge and ability with respect to: needs of the aged, characteristics of the aged, counseling services and techniques for the elderly client, and how did they differ in their self-ratings?

Instrumentation

As the literature review indicates, there are no instruments currently available which adequately assess the perceptions of aging program personnel towards counseling services for older persons. Several instruments evaluated attitudes towards aging and toward older persons; however, these were not sufficiently specific for the purposes of this study. Consequently, a new instrument was developed by the researcher based on the literature review and discussions with appropriate Aging Program staff and faculty at the University of Florida. The following actions describe the development of this instrument and the steps planned to assure its validity and reliability.

First, five major areas were selected for investigation. These areas corresponded to the topics suggested by the five research questions listed above and included the following:

Definition of Counseling
Role of Counseling/Counselors
Counseling in Relation to Other Services
Current Status of Counseling Services
Level of Knowledge (of Counseling and Aging)

Second, the conceptual validation of the comprehensiveness and importance of these five areas was accomplished. The researcher identified and contacted ten professionals currently employed in the Florida Health and Rehabilitative Services' Aging and Adult Services Program. Four administrative personnel, five direct service staff, and one from the State Office in Tallahassee, were selected. These individuals were representative of the three groups from which the larger sample of subjects was finally drawn. A member of the University of Florida Counselor Education faculty, skilled in instrument development, was asked to participate in this procedure. Each person was asked to review and comment on the five areas proposed for development in the questionnaire. Comments were received by telephone, face-to-face interviews, or written communications between the researcher and the participants. The researcher compiled these comments and developed questions based on their content. These topics provided the basis from which the initial draft of the questionnaire was developed. Approximately ten question items were developed in each of the five areas, as suggested by the reviewers' comments.

The first draft of the instrument was presented to the reviewers for the purpose of obtaining additional comments on the content, wording, and format. As a result of their appraisals, approximately one-half of the initial items were revised. A second revision was prepared, following discussions with these reviewers. Another group of ten employees was then selected with the same job classifications as the first group.

These personnel were asked to review and comment on the revised instrument, which they had not previously read. Their comments and suggestions were incorporated into those previously obtained. A final version of the instrument was developed consisting of 61 items related to the original five major component areas. Items 1-60 followed the Likert scale response format; item 61 was an open-ended question. The revised instrument was then resubmitted to both reviewing groups for comment (Appendix A).

A third group of ten reviewers, with the same job classifications as the first and second groups, who had not seen previous versions of the questionnaire was chosen to participate in this procedure. Comments were solicited regarding appropriateness of form, content, readability, language, clarity, length of time needed to complete, and types of demographic data requested.

The results of these three reviews indicated that the commentators agreed that the terminology utilized was appropriate for the topics. The questions were stated in terms which were familiar to them and which were felt to be suitable for the proposed subjects. The instructions, demographic data, and format were considered appropriate and clear. No further changes were suggested by the reviewers. The procedures involved in the development, review and revision of the instrument were accomplished during a three month time period. These methods established the conceptual and content validity of the instrument.

Verification of the realiability of the questionnaire was accomplished using the test-retest approach. Thirty subjects, including personnel from districts one, two, three and four of the Department of

HRS and the State Program Office, were chosen to represent the larger sample identified for the study. Figure 1 illustrates the geographic division of the 11 HRS districts in Florida. These subjects included administrators of aging programs, direct service supervisors and social workers, and purchase of service staff. Additionally, variations by level of education, sex, and race were analyzed, as noted in Table 1. Table 2 indicates work locations, sex and race of the 30 selected subjects.

The instrument was administered to the subjects at their work sites in each district, and in the State Program Office, by the researcher, using the Standardized Procedures for Administration of the Questionnaire (Appendix B).

After a two week interval, the instrument was readministered to the same group of subjects at their work locations by the researcher. Responses from these two administrations were analyzed to determine the reliability co-efficient of each item included in the instrument as shown in Table 3. Fifty-eight of the items were statistically significant at the .01 level and items 21 and 57 were significant at the .05 level. The data for the reliability study were analyzed employing the Statistical Package for the Social Sciences Program for correlation analysis using the Pearson r statistic. The originally selected acceptable level of reliability of .05 or better was met by all 60 items. Accordingly, the instrument in its final form was used for statewide administration.

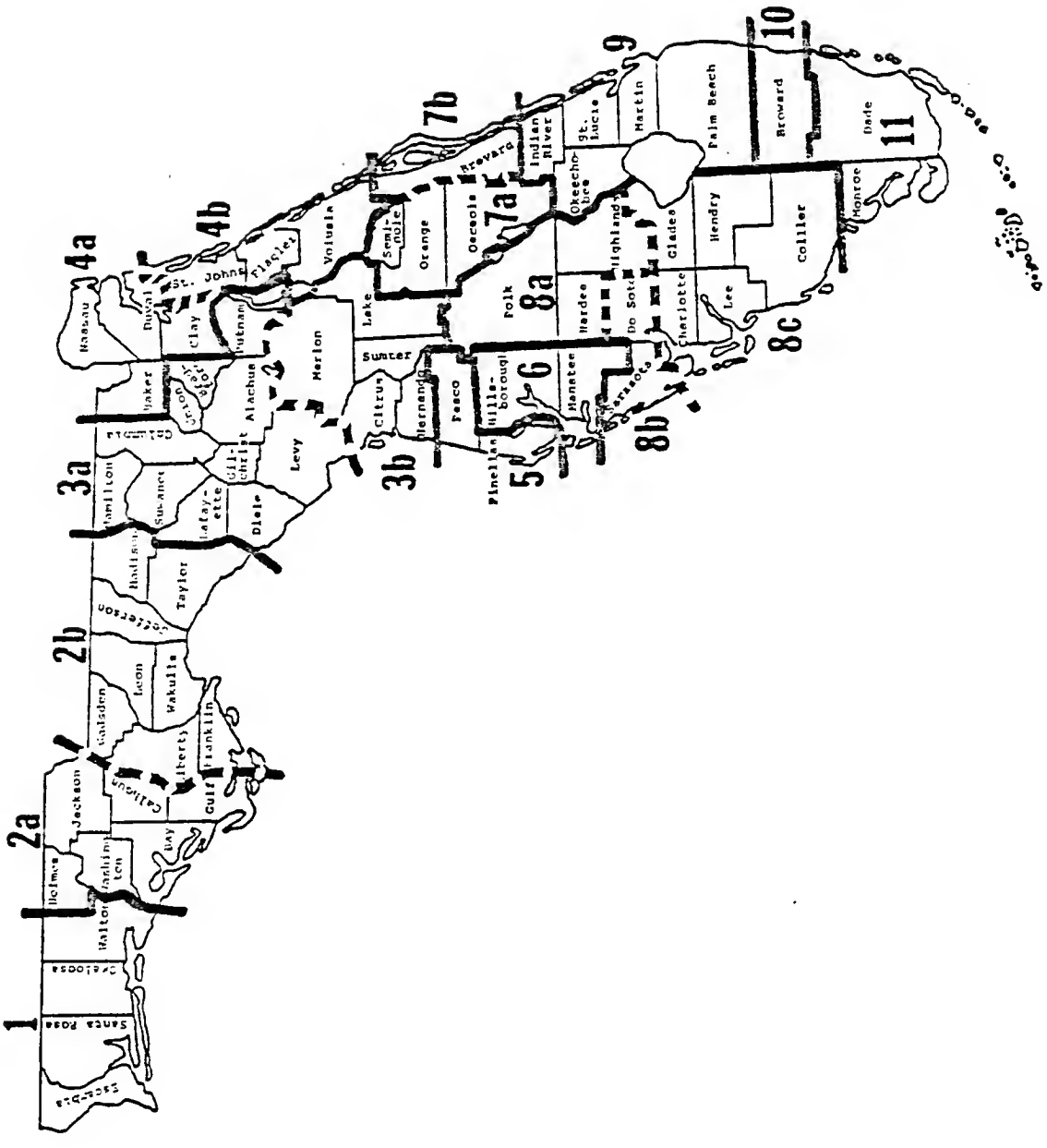

FIGURE 1

FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES DISTRICT BOUNDARIES

TABLE 1

LEVEL OF EDUCATION OF TEST RETEST SAMPLE
BY SEX AND RACE

Level of Education # %	Sex and Race Male White	 Ethnic Minority	 Female White	 Ethnic Minority	Total % Total
1. Grades 0-11	0 0.0	0 0.0	1 3.3	0 0.0	1 3.3
2. High School	0 0.0	0 0.0	2 6.7	3 10.0	5 16.7
3. A.A. Degree	0 0.0	0 0.0	1 3.3	0 0.0	1 3.3
4. 4 Year College Degree	6 20.0	0 0.0	10 33.3	1 3.3	17 56.7
5. Master's Degree	2 6.7	0 0.0	4 13.3	0 0.0	6 20.0
Total % Total	8 26.7	0 0.0	18 60.0	4 13.3	30 100.0

Total by Category and %	Male	8 26.7	Female	22 73.3
	Caucasian	26 86.7	Ethnic Minority	4 13.3

TABLE 2

WORK LOCATION OF TEST RETEST SAMPLE
BY SEX AND RACE

Work Location # %	Sex and Race Male White	 Ethnic Minority	 Female White	 Ethnic Minority	Total % Total
1. District I	0 0.0	0 0.0	1 3.3	1 3.3	2 6.7
2. District II	2 6.7	0 0.0	1 3.3	1 3.3	4 13.3
3. District III	4 13.3	0 0.0	14 46.7	2 6.7	20 66.7
4. District IV	0 0.0	0 0.0	1 3.3	0 0.0	1 3.3
5. State Office	2 6.7	0 0.0	1 3.3	0 0.0	3 10.0
Total %	8 26.7	0 0.0	18 60.0	4 13.3	30 100.0

TABLE 3

MEAN, STANDARD DEVIATION AND TEST RETEST CORRELATION COEFFICIENTS FOR PILOT TEST

Item Number	Mean	S.D.	r^+	Item Number	Mean	S.D.	r^+
1	1.47	.63	.58**	16	3.10	1.06	.71**
2	1.83	.99	.80**	17	3.17	1.02	.58**
3	1.83	.87	.93**	18	1.57	.82	.77**
4	2.33	.99	.88**	19	2.00	.83	.75**
5	2.37	1.03	.91**	20	2.77	.82	.67**
6	1.87	.86	.83**	21	3.67	.71	.38*
7	1.60	.67	.75**	22	1.83	1.09	.83**
8	1.57	.73	.72**	23	2.07	.83	.75**
9	1.33	.48	.78**	24	2.83	1.02	.72**
10	1.47	.63	.87**	25	3.30	.88	.63**
11	1.80	.66	.76**	26	2.93	.83	.71**
12	1.83	.75	.74**	27	2.77	.90	.71**
13	1.70	.79	.88**	28	2.27	.94	.79**
14	1.63	.67	.83**	29	2.70	.75	.55**
15	1.93	.69	.66**	30	2.03	.76	.76**

TABLE 3--continued

Item Number	Mean	S.D.	r^+	Item Number	Mean	S.D.	r^+
31	2.03	.81	.72**	46	2.20	.85	.64**
32	2.23	.90	.75**	47	1.63	.72	.61**
33	2.70	.92	.64**	48	2.23	.94	.78**
34	2.50	1.04	.74**	49	2.67	.88	.77**
35	1.77	.90	.66**	50	2.47	.82	.83**
36	2.00	.79	.79**	51	3.30	.75	.60**
37	2.10	.84	.84**	52	2.33	.92	.84**
38	1.77	.73	.70**	53	3.27	.87	.66**
39	1.90	.80	.80**	54	2.13	.68	.75**
40	2.07	.98	.80**	55	1.57	.63	.61**
41	2.33	.88	.68**	56	2.17	.95	.76**
42	2.20	.76	.78**	57	1.70	.60	.38*
43	2.20	.76	.76**	58	2.60	.93	.66**
44	2.17	.87	.83**	59	3.47	.73	.53**
45	2.33	.92	.66**	60	2.90	.80	.80**

Summary:

Mean & S.D.
Range of Mean = 1.47 - 3.67
Range of S.D. = .60 - 1.09

Pearson r
Mean - .73
Media - .75
Mode - .66, .75, .83
Range - .38 - .93
S.D. - .11
$S.E._M$ - .01

* $p \leq .05$
** $p \leq .01$
\+ two week interval

Subjects and Selection of Sample

Selection of subjects to participate in this study was based on the following considerations. Subjects were selected from current employees of the Florida Department of Health and Rehabilitative Services Aging and Adult Services Program staff. It was considered important to assess the perceptions of these groups because their job responsibilities include the planning, funding, and implementation of services and programs for Florida's older population. All federal funds allocated for expenditure in aging programs in Florida are administered or monitored by the Florida Department of Health and Rehabilitative Services. The attitudes of HRS employees towards counseling services for older persons were deemed crucial to the planning, implementation, administration, and monitoring of these programs.

Subjects were organized and studied by categories. The researcher identified three major groups from which subjects were selected. These included:

Category 1. Administrators of Aging Programs
Category 2. Direct Service Casework Supervisors and Social Workers
Category 3. Purchase of Service Staff

In Category One were all professional State Program Office staff, District Program Office staff, and Areawide Agency on Aging staff in Florida. Included in this category were the State Aging and Adult Services Program Office Director, Program Administrators, and Program Specialists, District Program Supervisors and Program Specialists, and Areawide Agency on Aging Directors and staff. A summary of job descriptions for all subjects involved in the study is included in Appendix C. There were approximately 128 persons in this

category. This number changes frequently due to routine personnel changes, position additions and deletions, budget limitations, and normal staff attrition. Included in Category One were 34 persons employed in the State Aging and Adult Services Program Office (PDAA) in Tallahassee, 39 persons employed in the 11 district Aging and Adult Services Program Offices, and 55 persons employed in the ten Areawide Agencies on Aging statewide. An attempt to survey all 128 of these persons was made and 115 were surveyed. Persons in this group have policy-making authority in aging programs in Florida, and determine funding and programming priorities. Thus, this group has direct impact on provision of services and fund expenditure.

The second category consisted of Specialized Adult Service Direct Service Casework Supervisors and Social Workers who were sampled, using a random selection procedure. There were approximately 433 persons in this group in Florida. This number changes frequently due to the reasons cited for Category One. In each of the 11 Health and Rehabilitative Services Districts in Florida, ten individual Aging and Adult Services Specialized Adult Services Casework Supervisors and Social Workers (SAS) and three alternates were selected for a total of 143 subjects in this category. There were 134 subjects from this group surveyed. The three alternates were selected for use in the event one or more of the ten primary subjects were absent on the day the instrument was administered. During the actual administration, most districts had all 13 persons at the site, consequently both primary and alternate subjects were surveyed for this category.

The selection procedure involved two steps. First, the Statewide Position Control Listing (a listing of all persons assigned

to the Aging and Adult Services Specialized Adult Services category by position number) was reviewed, and each position entity on the listing was assigned a number from a table of random numbers (Downie & Heath, 1970, p. 328-329). A second table of random numbers was used to select those numbers (13 from each of the 11 districts) which were surveyed as primary (ten) and alternate (three) subjects.

Category Three included Health and Rehabilitative Services Purchase of Service Project Directors and staff (POS). Included in this Category were Project Directors, meals program directors, transportation service providers, outreach coordinators, homemakers, and other project staff. There are currently more than 220 projects in Florida of which 21 provide counseling services (Appendix D). The same random selection procedures described for Category Two were used in sample selection for Category Three. There were approximately 1,300 Purchase of Service Project staff in Florida who were employed in approximately 220 projects statewide. The total number of projects and project staff fluctuates due to funding availibility. Category Three consisted of ten primary and three alternate Purchase of Service project staff from each of the 11 districts for a total of 143 persons. A total of 124 persons from this group were surveyed.

Total subjects contacted for the study was 414 persons. This total included: 128 in Category One; 143 in Category Two; and 143 in Category Three. There were 373 questionnaires completed for use in the study. The random selection procedure resulted in a sample which was representative of Health and Rehabilitative Services Aging and Adult Services social service personnel along major dimensions such as

rural/urban geographic location. A listing of the services for older persons provided by these Aging Program Staff is shown in Appendix E.

The minimum acceptable total sample size was 300 which represented a 72% rate of return. A minimum of 100 subjects was expected in each of the three categories. The N of 373 which was achieved and represented a 90.1% rate of return. The procedure of sampling by location and position resulted in the distribution of subjects shown in Table 4.

Procedures

The following procedures were developed for the administration of the questionnaire, to insure confidentiality, for assurances of cooperation, follow-up methods, and other considerations relevant to the implementation of the study.

The researcher developed a form to insure that each participant was made aware of the purpose of the study and of the confidentiality of the data gathered (Appendix A). This form was approved by the Human Subjects Review Board at the University of Florida, and was provided for each subject as a part of the questionnaire packet. Questions regarding confidentiality were answered by the researcher at each administration site, and the Standardized Procedures for Administration of the Questionnaire were followed at all administrations of the instrument. Each participant's signature on the form indicated voluntary participation in the study.

The study was made known to the Department of Health and Rehabilitative Services State Program Director for Aging and Adult Services. The approval and cooperation of the State Program Office

TABLE 4

CROSSTABULATION OF TOTAL SAMPLE CHARACTERISTICS:
LOCATION BY POSITION

Location	Position								
N % Total	State Office	District Supervisor	District Specialist	Area Agency	Project Administrator	Project Workers	SAS Supervisor	SAS Worker	Row Total
1		1 0.3	2 0.5	0 0.0	8 2.1	4 1.1	2 0.5	10 2.7	27 7.2
2		1 0.3	2 0.5	3 0.8	5 1.6	4 1.1	4 1.1	8 2.1	28 7.5
3		1 0.3	1 0.3	5 1.3	3 0.8	10 2.7	4 1.1	9 2.4	33 8.8
4		0 0.0	3 0.8	3 0.8	10 2.7	3 0.8	4 1.1	9 2.4	32 8.6
5		1 0.3	4 1.1	4 1.1	1 0.3	9 2.4	5 1.3	8 2.1	32 8.6
6		1 0.3	4 1.1	4 1.1	11 2.9	1 0.3	1 0.3	12 3.2	34 9.1

TABLE 4--Continued

Location	Position								
N % Total	State Office	District Supervisor	District Specialist	Area Agency	Project Administrator	Project Workers	SAS Supervisor	SAS Worker	Row Total
7		1 0.3	2 0.5	5 1.3	3 0.8	7 1.9	5 1.3	7 1.9	30 8.0
8		0 0.0	3 0.8	5 1.3	12 3.2	1 0.3	6 1.6	4 1.1	31 8.3
9		1 0.3	2 0.5	5 1.3	9 2.4	2 0.5	4 1.1	9 2.4	32 8.6
10		1 0.3	1 0.3	7 1.9	9 2.4	1 0.3	1 0.3	10 2.7	30 8.0
11		0 0.0	4 1.1	4 1.1	4 1.1	6 1.6	8 2.1	4 1.1	30 8.0
State Office	34 9.1								
Column Total	34 9.1	8 2.1	28 7.5	45 12.1	76 20.4	48 12.9	44 11.8	90 24.1	373 100.0

was given verbally and a written statement to this effect obtained. This endorsement of the study was made available to the subjects and referenced by the researcher when contacting participants for the study. The researcher announced the study at the statewide meeting of Aging and Adult Services administrative staff in November, 1978. By this means, the cooperation and support of each of the 11 HRS Aging and Adult Services Program Supervisors were obtained.

Administration of the questionnaire was accomplished by two methods. First, the researcher administered the questionnaire personally at nine work sites; and second, questionnaires were mailed when it was impossible for the researcher to visit work sites personally. With both methods, the Standardized Procedures for Administration of the Questionnaire were used exclusively to insure uniformity of administration.

The visits to the districts and State Program Office were preceeded by letters to the participants mailed two weeks in advance of the proposed date of the administration, which was previously agreed upon by telephone contact with the district Aging and Adult Services Program Supervisor or Specialist. A telephone call was made to the district Program Office one week in advance of the visit as a final reminder.

The researcher contacted each HRS District Office and the State Aging and Adult Services Program Office for the purposes of administering the instrument. Visits were made to these HRS headquarters offices and to field sites, to contact those participants who were unable to travel to the HRS District and State Headquarters Offices. The questionnaire was given to district administrative, supervisory, and

field staff at the same location and time in all instances. This group administration was accomplished by scheduling the administration of the questionnaire at the time of regularly scheduled district-wide meetings for the prupose of reducing travel cost and time investment by the participants. Questionnaire administration was conducted in the District headquarter's building conference room or Areawide Agency on Aging conference room, in all cases. Questionnaires were completed in no less than 10 and no more than 30 minutes in all cases. The percent of return of the questionnaires was 90.1 for the statewide sample. In the districts having Areawide Agencies on Aging, the HRS district headquarter's office is located in the same city as the Areawide Agency on Aging in all cases, enabling the researcher to visit both agencies with minimal travel between offices.

In those two districts where the researcher was unable to schedule an on-site visit, the Aging and Adult Services Program Supervisor or Specialist for the district was trained by telephone prior to the administration of the questionnaire in the administration of the questionnaire using the Standardized Procedures for Administration of the Questionnaire (Appendix B). All questions were answered and potential problems discussed at that time. The researcher then mailed the questionnaires to the district Program Supervisor with each questionnaire identified by the position number of the person to whom it was to be administered. A listing of the Standardized Procedures for Administration of the Questionnaire was included with the mailing to insure uniformity of administration. Also included was a stamped, self-addressed envelope for return of the questionnaires when completed. All questionnaires were completed and returned in a period of two weeks.

Following collection and analysis of the data, results of the research were provided to the participants. A summary of the results of the study was mailed to the State Aging and Adult Services Program Office and to each district Aging and Adult Services Program Office and Areawide Agency on Aging. All subjects were mailed a copy of the summary of the results of the study and copies of the discussion section of the study.

Data Analysis

After the questionnaires were administered and collected, the resulting data were prepared for statistical analysis. All questionnaires with no less than 75% of the items completed (46 of the possible 61 items) were considered complete for the purposes of the analysis. The researcher transferred the data from the 373 completed questionnaires to computer coding forms. Arrangements were then made for the data to be key punched onto data cards and prepared for computer analysis. Appropriate computer programs for the desired statistical analyses were selected from the Statistical Package for the Social Sciences Program Guidelines (Nie, 1970).

The main purpose of this study was to determine what perceptions Aging Program Staff in Florida held regarding counseling services for older persons. In order to determine what these perceptions for the total sample studied were, the mean and standard deviation response for each item were calculated. Frequency counts were calculated to determine if responses were normally distributed. Means and standard deviations for subgroups were calculated to determine if different subgroups responded similarly. The one-way analysis of variance was

accomplished to determine if differences were significant between groups of subjects. The Pearsonian r correlation was calculated to determine the degree of relationship between the demographic items and the test items. The Alpha level of .05 was chosen to represent statistical significance. Levels of .01 were also reported. Non-significant differences were calculated and reported as they occurred in various categories of interest.

Responses to the open-ended items on the instrument were tabulated manually to determine the nature and range of their content. Results obtained for these items are reported in Chapter IV.

Limitations of the Study

References dealing with research design denote several factors which may limit the valid interpretation of results (Campbell & Stanley, 1963; Isaac & Michael, 1971). In connection with this study, several factors should be noted which may have affected its validity and the usefulness of its results.

Bias may have been introduced through the selection procedures used. Although subjects were randomly chosen, there may have been other factors which determined those subjects who actually participated in and completed the study. Since participation was voluntary, there may have been differences between those who chose to join in the study and those who did not.

Additional bias may have been introduced preceding the actual administration of the questionnaire. The pre-test notifications and publicity may have had some unforeseen effects on some subjects. This advance notice may have served to increase some participants' awareness

of the topic, of their job performance with respect to counseling, and their attitudes towards it. However, prior notification was essential to insure adequate participation. No methods of determining the effects of this procedure appeared feasible for this research.

Pre-existing attitudes may have also influenced the perceptions of subjects toward counseling services. However, the use of the federal-state definition of counseling insured a standard interpretation of the term by all subjects. Otherwise, previously held attitudes and perceptions largely constituted the type of information which was sought.

Threats to the external validity and generalizability of this research may have been generated from several sources. As noted previously, the attitudes of participants in Florida may differ significantly from persons in similar positions in other locations. Consequently, generalizations beyond this population may be limited. However, it is believed that the sampling of the diverse geographic and population sites in Florida should have minimized this problem. In addition, although there are organizational differences among the states, the administration of aging programs and funds across the nation is probably more alike than not. The Areawide Agencies on Aging are part of a nationwide structure and are similar in many respects.

The possible reactive effects of the research procedures themselves may have had an effect on some participants. The presence of the researcher as one who both administered the questionnaire and observed its completion may have, in some manner, influenced some subjects. It is acknowledged that somewhat different responses might be obtained by using other procedures, such as individual interviews

or small group discussions on the subject of counseling services for older persons. Although it was stressed that participation was voluntary, some subjects may have felt an obligation to participate, and this sense of obligation may have had some influence on responses. As much as possible, the researcher administered the questionnaire in the same identical manner at each location in an effort to reduce the effects that possible procedural variations may have introduced.

It is also noted that changes in staffing patterns and nomenclature for HRS positions are under consideration currently, as reviewed in Appendix F. While position descriptions and educational requirements remain unchanged, the job titles may be changed from "Social Worker" to "Counselor." Should these changes occur, the definitions of counseling and the assignment of duties which fall under this definition might change. Such alterations could affect future attitudes towards counseling held by employees in these positions.

CHAPTER IV

RESULTS

The results of the data analysis, as described in Chapter III, are discussed in this chapter. The following topics are included: resulting sample, analysis of individual questionnaire items and responses, and discussion of the results in terms of the research questions. Analytical tables pertinent to these topics are presented with the discussion and additional data tables are included in the appendices. Significant items or those of particular interest are noted and discussed in detail. Responses to the open-ended Item 61 are reviewed.

Resulting Sample

As indicated in Chapter III, completed questionnaires were obtained from 373 Aging Program Staff in Florida. Responses to the demographic information section of the instrument form the basis of this discussion. Table 5 presents a summary of all sample demographic characteristics. The following discussion examines major components of these factors.

Age

As shown in Table 5, the age range of participants was from below 25 years to 71-80 years. Nearly one-half of the subjects were

TABLE 5

SUMMARY OF DEMOGRAPHIC CHARACTERISTICS OF SAMPLE

Characteristic	N	% Total
1. Age		
Under 25	17	4.6
25-35	157	42.2
36-45	62	16.7
46-55	79	21.2
56-60	32	8.6
61-70	21	5.6
71-80	4	1.1
Over 80	0	0.0
2. Sex		
Male	103	27.7
Female	269	72.3
3. Race		
Caucasian	323	86.6
Ethnic Minority	50	13.4

TABLE 5--Continued

Characteristic	N	% Total
4. Work Location		
District I	27	7.3
District II	28	7.5
District III	33	8.9
District IV	32	8.6
District V	32	8.6
District VI	34	9.1
District VII	30	8.1
District VIII	31	8.3
District IX	32	8.6
District X	29	7.8
District XI	30	8.1
State Program Office	34	9.1
5. Education		
Completed Grades 0-11	3	0.8
High School Graduate	51	13.7
Associate of Arts Degree	19	5.1
Four Year College Graduate	198	53.0
Master's Degree	91	24.5
Ed.S. Degree	4	1.2
Ph.D.	2	0.5
Other	4	1.2
6. Subject in Which Highest Degree was Earned		
Administration	31	8.3
Counseling	17	4.8
Social Work	93	25.2
Gerontology	9	2.4
Psychology	26	7.0
Sociology	32	8.6
Other	164	43.7

TABLE 5--Continued

Characteristic	N	% Total
7. Present Position Title		
State Program Office	34	9.1
District Program Office Staff	36	9.7
Area Agency on Aging Staff	45	12.1
Aging Project Staff	124	33.1
Specialized Adult Services Staff	134	36.0
8. Number of Years in Present Position		
Less than 2 years	156	41.9
2-5 years	138	37.1
6-10 years	45	12.1
11-15 years	21	5.7
16-25 years	10	2.7
26-35 years	2	0.5
Over 35 years	0	0.0
9. Special Training or Experience in Working with Older Persons		
Yes	237	63.9
No	134	36.1
10. Special Training or Experience in Counseling		
Yes	206	55.8
No	163	44.2

younger than 35 years. It is of interest that only 6.7% of these employees were 60 years or older. Most subjects fell in the 25-35 year age range, with 157 persons, representing 42.2% of the total sample, occurring in this range. The smallest numbers were found among the oldest group, the 71-80 years old, with four persons or 1.1% of the total sample in this range.

Sex and Race

The sample was predominantly female: 72.3% of the subjects were women; and 27.7% male. Similarly, a large majority of participants were Caucasian; 86.6%. The remaining 13.4% described themselves as representing an ethnic minority.

Educational Level

The educational level and professional fields of the subjects provided an interesting profile. Overall, the sample was well-educated, with more than half (53.0%) reporting completion of a four year college degree. Associate of Arts degrees or less education was reported by 19.6% of the group. Advanced degrees were held by 27.9% of the sample.

In terms of area specialization or academic major, most (25.2%) had degrees in social work and several (8.6%) in Sociology. Degrees in administration were reported by 8.3%. Least represented were counseling (4.8%) and gerontology(2.4%). Among those with advanced degrees, four persons (1.2%) had law degrees.

Most subjects (42.7%) received their college training in a variety of "other" fields. Included in this category were those with

degrees in education (16), nutrition (8), history (3), music education (3), nursing (3), and criminal justice (3). Two or fewer subjects also reported degrees in each of the following academic areas: urban planning, fine arts, humanities, anthropology, recreation therapy, speech, art, public relations, Spanish, zoology, and business administration.

Job Classification

Sample participants represented the various job categories of the aging network. The Aging and Adult Services State Program Office in Tallahassee comprised 9.1% or 24 persons. At the District level, Aging and Adult Services Staff totalled 36 persons or 9.7%. The Area-wide Agency on Aging programs were represented by 45 persons or 12.1% of the sample. Aging project staff included 123 persons or 33.1% of the total. Specialized Adult Services employees composed the remaining 36.0% or 135 subjects.

Number of Years Worked

Those subjects reporting less than two years in their current job classifications represented 41.9% of the total, or 156 persons. Those working from two to five years included 138 subjects or 37.1% of the total. In the six to ten year category were 45 persons or 12.1% of the sample. Those employed the longest periods of time included: for 11 to 15 years, 21 persons or 5.7%; for 16-35 years, 10 persons or 2.7%; and two persons, representing 0.5% who had worked from 26-35 years. None of the sample had been employed longer than 35 years in his/her present position.

Special Training in Gerontology

Of those subjects who answered this item, 257 (63.9%) indicated they had received some type of special training relating to working with older persons. The remaining 134 persons reported no such experiences. In conjunction with this question, subjects responding in the affirmative were asked to briefly describe their special training. Many of these responses indicated the training was received in the form of workshops they attended after becoming employed in their present positions. Relatively few subjects reported specific education or training in gerontology prior to employment.

Special Training in Counseling

Subjects were also asked to indicate their preparation in the field of counseling. Of those responding, 206 or 55.8% noted some training in this area. The remainder, 163 or 44.2%, reported no preparation. As in the item related to gerontological training, the majority of respondents described their counseling training as occurring during and/or because of their current employment. Again, few subjects were prepared in counseling prior to becoming employed in their present positions. Participants, however, did indicate more training in gerontological topics then they claimed in counseling skills.

Data for the demographic information portion of the questionnaire were also analyzed by crosstabulations of items. Tabular displays of the results of these procedures are included in this chapter and in the Appendices. The following sections discuss these results.

Table 6 displays the crosstabulation of the sex and racial group characteristics of the sample. Of the respondents, 95 or 25% were male Caucasians and 228 or 61.0% were female Caucasians. Fifty persons indicated belonging to an ethnic minority, comprising 13.4% of the sample. Ethnic minority males were the least represented, providing 2.1% or 8 persons in the sample. Female minority members totalled 42 or 11.3%.

A crosstabulation of sample characteristics classified by position title, sex, and race, is displayed in Table 7. The State Program Office for Aging and Adult Services included 15 Caucasian males and 17 Caucasian females, which accounted for 4.0% and 4.6% of the total sample, respectively. District Program Office Staff included 11 Caucasian males and 20 Caucasian females, or 3.0% and 5.4% of the total sample occurring in these categories, respectively. Six ethnic minority females and one minority male were employed in the district and state Aging and Adult Services Program Offices combined.

Areawide Agency on Aging staff included ten Caucasian males, or 2.6% of the sample, and 33 Caucasian females, or 8.9% of the sample. There were two ethnic minority females sampled from this subgroup. No ethnic minority males were reported in the Areawide Agency on Aging subsample.

Specialized Adult Services staff included one ethnic minority male; however, there were 32 Caucasian males, 82 Caucasian females and 19 ethnic minority females. In contrast, the aging project staff sampled included 75 Caucasian females, 15 ethnic minority females, 27 Caucasian males, and six ethnic minority males.

TABLE 6

CROSS TABULATION OF SAMPLE CHARACTERISTICS:
SEX BY RACE

Sex N % Total	Race Caucasian	 Ethnic Minority
Male	95 25.5	8 2.1
Female	228 61.1	42 11.3
Total	323 86.6	50 13.4

TABLE 7

CROSSTABULATION OF SAMPLE CHARACTERISTICS:
POSITION TITLE BY SEX AND RACE

Position	Race			
N % Total	Caucasian		Ethnic Minority	
	Sex		Sex	
	Male	Female	Male	Female
State Office	15 4.0	17 4.6	0 0.0	2 .5
District Program Staff	11 3.0	20 5.4	1 .3	4 1.1
AAA Staff	10 2.6	33 8.9	0 0.0	2 .5
Project Staff	27 7.3	75 20.2	6 1.6	15 4.0
SAS Staff	32 8.6	82 22.0	1 .3	19 5.1
Total	95 25.5	227 61.0	8 2.2	42 11.3

Demographic items nine and 11 related to special training and experience in working with older persons or in counseling and were crosstabulated by sex and race. As shown in Table 8, 58 Caucasian males reported special training or experience in working with the elderly, 37 subjects in this category reported no such experience. Minority males indicated special training in four cases and four others in this subgroup reported no special training or experience. Caucasian females were evenly divided; 147 reported receiving training or experience, while 79 others did not. Twenty-eight minority females indicated training or experience; 14 in this group responded negatively.

Table 8 presents a similar breakdown of the respondents' reported experience and specialized training in counseling. Caucasian female respondents reported affirmatively in 118 cases; 106 subjects indicated no such backgrounds in either training or experience. Twenty-seven ethnic minority females reported training or experience; 15 of the subjects reported none. Caucasian males were apparently trained or experienced in 58 cases, and not so in 37. Minority males were evenly divided on this variable: four reported no training or experience in counseling, while four responded positively.

Table 9 provides a crosstabulation of position by education and sex. In the extreme, the State Program Office group contained the only two Ph.D. staff sampled, while there were two persons on the specialized adult services staff, and one person working in an aging project, who had not attained high school education. Female Specialized Adult Service staff who had received four year college degrees numbered 84 persons, or 22.6% of the sample. There were 18 Areawide Agency on Aging female staff with Master's degrees and this sub-group accounted

TABLE 8

CROSSTABULATION OF SAMPLE CHARACTERISTICS:
SPECIAL TRAINING OR EXPERIENCE IN WORKING WITH
OLDER PERSONS AND COUNSELING BY SEX AND RACE

N % Total	Race			
	Caucasian		Ethnic Minority	
	Sex		Sex	
	Male	Female	Male	Female
Working with Older Persons				
Yes	58 15.6	147 39.6	4 1.1	28 7.5
No	37 10.0	79 21.3	4 1.1	14 3.8
Total	95 25.6	226 60.9	8 2.2	42 11.3
Counseling				
Yes	57 15.4	118 32.0	4 1.1	27 7.3
No	38 10.3	106 28.7	4 1.1	15 4.1
Total	95 25.7	224 60.7	8 2.2	42 11.4

TABLE 9

CROSSTABULATION OF SAMPLE CHARACTERISTICS:
POSITION BY EDUCATION AND SEX

Education N % Total	Position									
	State Program Office Staff		District Program Staff		AAA Staff		Project Staff		SAS Staff	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Grades 0-11	0	0	0	0	0	0	0	1	0	2
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.5
High School	0	0	1	0	0	1	7	38	0	4
	0.0	0.0	0.3	0.0	0.0	0.3	1.9	10.2	0.0	1.1
AA Degree	0	0	0	0	1	4	5	8	0	1
	0.0	0.0	0.0	0.0	0.3	1.1	1.3	2.2	0.0	0.3
Four Year Degree	1	3	5	14	7	12	12	31	29	84
	0.3	0.8	1.3	3.8	1.9	3.2	3.2	8.3	7.8	22.7
Master's Degree	10	14	5	9	2	18	8	11	4	10
	2.7	3.8	1.3	2.4	0.5	4.8	2.2	3.0	1.1	2.7
Ed.S. Degree	0	1	1	1	0	0	0	1	0	0
	0.0	0.3	0.3	0.3	0.0	0.0	0.0	0.3	0.0	0.0
Ph.D.	1	1	0	0	0	0	0	0	0	0
	0.3	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	3	0	0	0	0	0	1	0	0	0
	0.8	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.0	0.0
Total	15	19	12	24	10	35	33	90	33	101
	4.0	5.1	3.2	6.5	2.7	9.4	8.9	24.2	8.9	27.2

for 4.8% of the sample. The State Program Office had 24 persons with Master's degrees or 6.5% of the total sample.

A crosstabulation of number of years in present position by sex and race is presented in Table 10. Two Caucasian females included in the sample had been employed for 26-35 years, while 108 of this category had been employed for less than two years. Only one ethnic minority female fell in the 16-25 years of service category, while 17 of these females reported that they had been in their present positions less than two years.

Four Caucasian males were in the 11-15 years of service category and there was one ethnic minority male with six to ten years tenure in his present position. Of the Caucasian males, 46 of the 95 reporting on this item had been employed in their present positions from two to five years.

Further analysis of sample characteristics is shown in Table 11. This table includes a crosstabulation of position by education and subject. Of the 34 respondents employed in the State Program Office, one individual had a Master's degree in Gerontology. None among those sampled in the District Program Office staff reported degrees in the field of gerontology. However, five Areawide Agency on Aging staff indicated that they held Master's degrees in Gerontology. The remainder of respondents in this category included one four year degree and one Master's degree among the project staff, and one Master's degree among the specialized adult services staff. To summarize, there were nine total respondents who indicated that they had four year or Master's degrees in Gerontology.

TABLE 10

CROSSTABULATION OF SAMPLE CHARACTERISTICS:
NUMBER OF YEARS IN PRESENT POSITION BY SEX AND RACE

Years	Race			
N % Total	Caucasian		Ethnic Minority	
	Sex		Sex	
	Male	Female	Male	Female
Less Than 2	30 8.1	108 29.0	1 .3	17 4.6
2-5 Years	46 12.4	72 19.4	6 1.6	14 3.8
6-10 Years	15 4.0	25 6.7	1 .3	4 1.1
11-15 Years	4 1.1	11 3.0	0 0.0	6 1.6
16-25 Years	0 0.0	9 2.4	0 0.0	1 .3
26-36 Years	0 0.0	2 .5	0 0.0	0 0.0
Over 36 Years	0 0.0	0 0.0	0 0.0	0 0.0
Total	95 25.5	227 61.0	8 2.2	42 11.3

TABLE 11

CROSSTABULATION OF SAMPLE CHARACTERISTICS:
POSITION BY EDUCATION AND SUBJECT

Position N	Education	Subject							
		Administration	Counseling	Social Work	Gerontology	Psychology	Sociology	Other	Total
1. State Program Office Staff	0-11	0	0	0	0	0	0	0	0
	H.S.	0	0	0	0	0	0	0	0
	AA	0	0	0	0	0	0	0	0
	Four Yr.	0	0	1	0	0	1	2	4
	M.S.	1	3	12	1	0	2	5	24
	Ed.S.	1	0	0	0	0	0	0	1
	Ph.D.	1	1	0	0	0	0	0	2
	Other	1	0	0	0	0	0	2	3
2. District Program Office Staff	0-11	0	0	0	0	0	0	0	0
	H.S.	0	0	0	0	0	0	1	1
	AA	0	0	0	0	0	0	0	0
	Four Yr.	0	0	7	0	4	3	5	19
	M.S.	1	1	8	0	0	0	4	14
	Ed.S.	1	1	0	0	0	0	0	2
	Ph.D.	0	0	0	0	0	0	0	0
	Other	0	0	0	0	0	0	0	0

TABLE 11--Continued

Position N	Education	Subject: Administration	Counseling	Social Work	Gerontology	Psychology	Sociology	Other	Total
3. Area Agency On Aging	0-11	0	0	0	0	0	0	0	0
	H.S.	0	0	0	0	0	0	1	1
	AA	3	0	0	0	0	0	2	5
	Four Yr.	4	0	4	0	1	2	7	18
	M.S.	2	3	5	5	0	0	5	20
	Ed.S.	0	0	0	0	0	0	0	0
	Ph.D.	0	0	0	0	0	0	0	0
	Other	0	0	0	0	0	0	0	0
4. Project Staff	0-11	0	0	0	0	0	0	1	1
	H.S.	1	0	0	0	1	0	43	45
	AA	0	0	2	0	0	0	11	13
	Four Yr.	4	3	11	1	4	4	17	44
	M.S.	1	1	6	1	1	2	7	19
	Ed.S.	0	1	0	0	0	0	0	1
	Ph.D.	0	0	0	0	0	0	0	0
	Other	0	0	0	0	0	0	0	0
5. Specialized Adult Services Staff	0-11	0	0	0	0	0	0	2	2
	H.S.	0	0	0	0	0	0	4	4
	AA	0	0	1	0	0	0	0	1
	Four Yr.	10	1	3	0	14	17	40	103
	M.S.	0	2	5	1	1	1	3	13
	Ed.S.	0	0	0	0	0	0	0	0
	Ph.D.	0	0	0	0	0	0	0	0
	Other	0	0	0	0	0	0	0	0
Total		31	17	93	9	26	32	164	372

The largest category in terms of education subject area included those persons with degrees in social work. Thirteen persons on the State Program Office staff reported degrees in social work. District Program staff had 15 social work degree recipients; Areawide Agency on Aging staff had nine; Project staff, 19; and Specialized Adult Services staff, 37. The total of 93 social work degree recipients is second only to the "other" category, previously discussed (Table 5) which included 164 persons.

The least educated subgroup was the project staff category. These included 46 individuals with high school or below educational attainment, and 13 persons with Associate of Arts degrees. In contrast, District Program Office staff had only one person in the high school and below category; 19 persons had four year degrees; 14 persons, Master's degrees; and two persons, with Specialist degrees.

Additional information concerning the sample characteristics may be found in Appendices G through M. These appendices include cross-tabulations of sample characteristics for academic subject in which highest degree was earned, by sex and race; educational level, by sex and race; work location, by sex and race; education by subject in which highest degree was earned; age, by sex and race; work location, by age and sex; and position, by age and sex.

Analysis of Questionnaire Responses

Subjects' responses to the individual items of the survey instrument are discussed in this section. An overview is provided of the analyses performed, general response patterns, and significant

results. Specific item analysis follows the discussion of the tabular display of results.

Summary of Tables

The results of the investigation are presented in tabular form representing various analyses of subjects' responses to the questionnaire and demographic data forms. As all questionnaire items are not alike in format and response categories, the summary tables vary also. Therefore, a brief overview of the structure and content of data tables is necessary to facilitate understanding of the discussion of the results.

Tables 12, 13, and 14 provide summaries of the frequencies of response choices, means, and standard deviations of the survey items. The three tables are divided by those sections of the questionnaire which include similarly structured items and response formats. Table 12 includes questionnaire items 1-13, 26-35, and 47-60. Table 13 (items 14-25) includes the questions regarding rank ordering of several variables. Table 14 presents the frequencies of responses, means, and standard deviations for items 35-46. (Survey item 61, an open-ended question, is discussed separately in a later section of this Chapter).

Tables 15 and 16 display statistical summaries for responses of subjects when classified by specific position titles and work locations. These two factors were considered of major significance and interest for the study. Means and standard deviations calculated for the other demographic characteristics appear in Appendices N through Q. Table 17 summarizes F ratios obtained through the one-way analysis of variance procedures completed for questionnaire items 1-60. Table 18 displays

TABLE 12

FREQUENCY OF RESPONSE CHOICES, MEAN, AND STANDARD DEVIATION OF SURVEY ITEMS, 1-13, 27-35, 47-60

Item Number	% of Subjects Responding: Strongly Agree	Agree	Disagree	Strongly Disagree	$\bar{X}$	S.D.
1	42.1	53.4	4.0	0.5	1.63	.59
2	7.4	57.7	26.9	8.0	2.35	.73
3	20.3	51.4	22.7	5.7	2.14	.80
4	10.5	39.1	43.4	7.0	2.47	.77
5	8.6	34.1	46.0	11.3	2.60	.80
6	22.3	53.1	21.7	2.9	2.05	.75
7	53.4	42.9	2.7	1.1	1.51	.61
8	43.4	46.4	7.8	2.4	1.69	.72
9	53.6	41.3	4.0	1.1	1.53	.63
10	46.4	45.3	7.0	1.3	1.63	.67
11	23.5	51.1	22.7	2.7	2.05	.75
12	19.9	52.7	24.7	2.7	2.10	.74
13	33.3	43.5	17.5	5.6	1.95	.86
*						
26	1.6	26.3	54.8	17.2	2.88	.70
27	10.3	31.3	37.5	20.9	2.69	.92
28	7.3	51.8	33.9	7.0	2.41	.73
29	4.8	34.7	39.5	21.0	2.77	.84
30	10.2	58.3	26.9	4.6	2.26	.70
31	9.7	60.8	23.1	6.5	2.26	.72
32	7.0	50.3	37.0	5.7	2.41	.71
33	2.4	39.6	46.3	11.7	2.67	.71
34	10.8	28.6	45.8	14.8	2.65	.86
35	17.3	25.6	44.7	12.4	2.52	.92
**						

TABLE 12--Continued

Item Number	% of Subjects Responding: Strongly Agree	Agree	Disagree	Strongly Disagree	$\bar{X}$	S.D.
47	43.4	37.3	17.7	1.6	1.77	.79
48	16.4	63.2	18.3	2.2	2.06	.66
49	5.6	40.5	41.0	12.9	2.61	.78
50	9.9	54.4	30.0	5.6	2.31	.73
51	1.6	5.4	39.9	53.1	3.45	.67
52	12.6	20.7	54.6	21.1	2.66	.85
53	1.1	2.4	45.2	51.3	3.47	.60
54	6.0	61.8	26.6	5.7	2.32	.67
55	40.9	55.4	3.5	0.3	1.63	.57
56	7.8	14.2	52.2	25.8	2.96	.84
57	32.8	56.7	9.4	1.1	1.79	.65
58	4.8	27.1	59.5	8.6	2.72	.69
59	0.3	9.9	53.0	36.8	3.26	.64
60	1.4	18.2	61.2	19.2	2.98	.66

Summary
Range of $\bar{X}$ = 151-347
Range of S.D. = .57-.92

* Items 14-25 have a different response format and are included in Table 13.

** Items 36-46 have a different response format and are included in Table 14.

TABLE 13

FREQUENCY OF RESPONSE CHOICES,
MEAN AND STANDARD DEVIATION OF SURVEY ITEMS 14-25

Rank Order of Priority Services Item #		Greatest Need	Great Need	Less Need	Least Need	$\bar{X}$	S.D.
14	Transportation	47.5	41.8	8.3	2.4	1.66	.73
15	Home Services	45.6	39.7	12.3	2.4	1.72	.77
16	Legal and Other Counseling	9.1	10.2	37.3	43.4	3.15	.94
17	Residential Repair	4.8	8.3	40.2	46.6	3.29	.81
18	Transportation	48.8	35.1	9.4	6.7	1.74	.86
19	Home Services	41.0	41.3	12.9	4.8	1.82	.84
20	Legal and Other Counseling	9.1	14.5	45.6	30.8	2.98	.91
21	Residential Repair	2.1	8.3	28.7	60.9	3.48	.74
22	Transportation	43.4	22.5	18.2	15.8	2.06	1.12
23	Home Services	27.6	35.4	25.5	11.5	2.21	.98
24	Legal and Other Counseling	25.2	26.3	29.2	19.3	2.43	1.07
25	Residential Repair	6.2	13.9	25.5	54.4	3.28	.92

Summary

Range of $\bar{X}$ = 1.66 - 3.48
Range of S.D. = .73 - 1.12

TABLE 14

FREQUENCY RESPONSE CHOICES,
MEAN AND STANDARD DEVIATION OF SURVEY ITEMS 36-46

Item # / Level of Knowledge	Comprehensive	Adequate	Limited	Inadequate	$\overline{X}$	S.D.
36	44.0	43.2	9.7	3.2	1.72	.77
37	25.0	43.3	27.4	4.3	2.11	.83
38	39.7	46.9	12.1	1.3	1.75	.71
39	32.2	44.8	20.4	2.7	1.94	.79
40	40.9	43.3	11.3	4.6	1.80	.82
41	16.3	39.7	37.8	6.3	2.34	.82
42	16.6	37.0	36.2	10.2	2.40	.88
43	18.8	39.1	32.2	9.9	2.33	.89
44	18.4	43.5	30.8	7.3	2.27	.84
45	11.8	36.6	41.9	9.7	2.49	.83
46	11.0	40.2	37.8	11.0	2.49	.83

Summary:

Range of $\overline{X}$ = 1.72 - 2.49
Range of S.D. = .71 - .89

TABLE 15

ITEM MEANS (AND STANDARD DEVIATIONS) FOR SPECIFIED POSITION TITLES

Item Number	State Program Office	District Program Office	Area Agency On Aging Staff	Project Staff	Specialized Adult Services Staff
1	1.79	1.64	1.76	1.60	1.57
	(.77)	(.64)	(.68)	(.52)	(.54)
2	2.79	2.64	2.56	2.24	2.20
	(.84)	(.80)	(.84)	(.67)	(.62)
3	2.44	2.14	1.98	2.06	2.19
	(.82)	(.80)	(.66)	(.79)	(.83)
4	2.71	2.53	2.44	2.31	2.54
	(.76)	(.77)	(.66)	(.77)	(.80)
5	2.85	2.61	2.64	2.53	2.58
	(.70)	(.84)	(.68)	(.80)	(.84)
6	2.47	1.97	2.20	2.10	1.87
	(.79)	(.65)	(.73)	(.77)	(.69)
7	1.56	1.56	1.60	1.50	1.48
	(.70)	(.69)	(.72)	(.59)	(.53)
8	1.56	1.58	1.60	1.73	1.75
	(.66)	(.69)	(.65)	(.78)	(.70)
9	1.79	1.50	1.53	1.60	1.40
	(.77)	(.56)	(.59)	(.66)	(.56)
10	2.09	1.58	1.60	1.78	1.40
	(.79)	(.65)	(.62)	(.67)	(.58)
11	2.50	2.11	1.98	1.99	1.98
	(.99)	(.80)	(.66)	(.70)	(.72)
12	2.53	2.17	2.13	2.15	1.92
	(.86)	(.70)	(.76)	(.71)	(.68)
13	2.62	2.14	2.00	1.97	1.71
	(.89)	(.72)	(.83)	(.90)	(.75)
14	1.62	1.81	1.62	1.52	1.77
	(.65)	(.71)	(.78)	(.69)	(.77)
15	1.79	1.56	1.67	1.89	1.60
	(.88)	(.77)	(.71)	(.80)	(.72)
16	3.12	3.19	3.22	3.16	3.11
	(.91)	(.89)	(.82)	(.97)	(.98)
17	3.47	3.44	3.44	3.17	3.25
	(.66)	(.65)	(.66)	(.91)	(.83)
18	1.59	1.89	1.64	1.73	1.78
	(.61)	(.85)	(.71)	(.97)	(.92)
19	1.53	1.56	1.78	1.98	1.82
	(.56)	(.69)	(.82)	(.93)	(.81)
20	3.24	3.03	3.04	2.99	2.87
	(.70)	(.84)	(.97)	(.93)	(.91)

TABLE 15--Continued

Item Number	State Program Office	District Program Office	Area Agency On Aging Staff	Project Staff	Specialized Adult Services Staff
21	3.65 (.49)	3.56 (.73)	3.49 (.66)	3.28 (.84)	3.60 (.68)
22	2.15 (1.10)	2.19 (1.14)	2.73 (1.10)	2.04 (1.16)	1.81 (.99)
23	2.38 (1.04)	2.30 (1.06)	1.87 (.89)	2.25 (.98)	2.22 (.94)
24	2.41 (1.05)	2.58 (1.13)	2.20 (1.14)	2.52 (1.11)	2.38 (.99)
25	3.06 (1.13)	2.92 (1.05)	3.16 (.90)	3.14 (.95)	3.61 (.70)
26	3.15 (.66)	3.22 (.68)	3.18 (.53)	2.78 (.68)	2.70 (.69)
27	2.41 (.78)	2.64 (.96)	2.64 (.83)	2.57 (.91)	2.90 (.94)
28	2.68 (.77)	2.31 (.67)	2.40 (.65)	2.53 (.71)	2.26 (.75)
29	3.09 (.75)	2.67 (.72)	2.82 (.81)	2.63 (.84)	2.81 (.87)
30	2.47 (.86)	2.50 (.74)	2.33 (.56)	2.26 (.69)	2.11 (.67)
31	2.53 (.86)	2.33 (.68)	2.26 (.65)	2.28 (.70)	2.15 (.72)
32	2.62 (.82)	2.43 (.65)	2.40 (.54)	2.46 (.69)	2.32 (.74)
33	2.79 (.77)	2.78 (.64)	2.64 (.53)	2.56 (.71)	2.73 (.76)
34	2.73 (.84)	2.75 (.77)	2.67 (.83)	2.68 (.94)	2.56 (.83)
35	2.59 (.99)	2.55 (.88)	2.62 (.89)	2.53 (.96)	2.46 (.90)
36	1.85 (.66)	1.64 (.68)	1.71 (.97)	1.84 (.89)	1.60 (.67)
37	2.21 (.84)	1.83 (.81)	2.20 (.76)	2.35 (.89)	1.91 (.73)
38	1.76 (.65)	1.58 (.69)	1.78 (.79)	1.85 (.75)	1.71 (.67)
39	2.00 (.82)	1.64 (.59)	1.84 (.93)	2.06 (.81)	1.92 (.76)
40	1.85 (.70)	1.56 (.56)	1.53 (.73)	2.01 (.90)	1.73 (.81)

TABLE 15--Continued

Item Number	State Program Office	District Program Office	Area Agency On Aging Staff	Project Staff	Specialized Adult Services Staff
41	2.62	2.11	2.42	2.41	2.23
	(.82)	(.82)	(.84)	(.87)	(.75)
42	2.21	2.11	2.38	2.57	2.37
	(.98)	(.92)	(.98)	(.87)	(.81)
43	2.09	2.06	2.33	2.55	2.27
	(.90)	(.92)	(1.00)	(.92)	(.78)
44	2.35	2.03	2.33	2.38	2.19
	(.92)	(.86)	(.95)	(.85)	(.76)
45	2.74	2.20	2.56	2.56	2.43
	(.83)	(.80)	(.87)	(.85)	(.78)
46	2.79	2.22	2.49	2.57	2.40
	(.77)	(.76)	(.90)	(.89)	(.77)
47	1.68	1.69	1.73	1.75	1.86
	(.77)	(.75)	(.81)	(.86)	(.74)
48	2.12	2.17	2.02	1.96	2.13
	(.73)	(.65)	(.78)	(.64)	(.60)
49	2.53	2.69	2.71	2.46	2.72
	(.79)	(.67)	(.90)	(.74)	(.79)
50	2.09	2.42	2.44	2.36	2.25
	(.71)	(.69)	(.76)	(.76)	(.69)
51	3.41	3.61	3.58	3.35	3.46
	(.66)	(.64)	(.54)	(.75)	(.63)
52	2.53	2.58	2.42	2.69	2.77
	(.83)	(.77)	(.92)	(.86)	(.83)
53	3.53	3.56	3.49	3.46	3.43
	(.51)	(.50)	(.73)	(.58)	(.63)
54	2.45	2.78	2.40	2.37	2.22
	(.56)	(.61)	(.69)	(.69)	(.68)
55	2.45	2.28	2.40	2.37	2.22
	(.56)	(.61)	(.69)	(.69)	(.68)
56	1.56	1.61	1.62	1.65	1.64
	(.50)	(.69)	(.53)	(.57)	(.56)
57	1.71	1.75	1.82	1.90	1.70
	(.58)	(.65)	(.49)	(.69)	(.66)
58	2.53	2.81	2.67	2.67	2.18
	(.71)	(.67)	(.74)	(.66)	(.69)
59	3.38	3.31	3.38	3.15	3.29
	(.55)	(.52)	(.58)	(.70)	(.65)
60	3.15	3.28	3.18	2.97	2.81
	(.66)	(.51)	(.53)	(.68)	(.65)

TABLE 16

ITEM MEANS (AND STANDARD DEVIATIONS) FOR WORK LOCATION

Item #	State Office	Districts 1	2	3	4	5	6	7	8	9	10	11
1	1.79	1.63	1.64	1.67	1.69	1.53	1.59	1.60	1.81	1.47	1.63	1.50
	(.77)	(.57)	(.49)	(.60)	(.54)	(.57)	(.66)	(.56)	(.54)	(.57)	(.61)	(.51)
2	2.79	2.30	2.15	2.50	2.26	2.10	2.45	2.27	2.43	2.26	2.23	2.41
	(.84)	(.82)	(.78)	(.80)	(.58)	(.65)	(.67)	(.69)	(.57)	(.82)	(.50)	(.82)
3	2.44	2.00	2.30	1.91	2.06	2.06	2.24	2.13	2.35	2.03	2.03	2.07
	(.82)	(.88)	(.82)	(.80)	(.67)	(.84)	(.83)	(.82)	(.84)	(.82)	(.61)	(.75)
4	2.71	1.96	2.54	2.24	2.50	2.56	2.65	2.57	2.74	2.31	2.33	2.43
	(.76)	(.76)	(.84)	(.71)	(.57)	(.72)	(.77)	(.90)	(.63)	(.90)	(.76)	(.73)
5	2.85	2.19	2.61	2.56	2.56	2.56	2.79	2.70	3.00	2.38	2.47	2.43
	(.70)	(.74)	(.88)	(.84)	(.76)	(.72)	(.73)	(.84)	(.63)	(.91)	(.82)	(.82)
6	2.47	1.74	2.00	2.00	2.03	1.81	2.24	2.10	2.10	1.96	2.03	2.47
	(.79)	(.76)	(.67)	(.83)	(.65)	(.69)	(.65)	(.76)	(.60)	(.82)	(.78)	(.76)
7	1.56	1.33	1.68	1.45	1.72	1.41	1.38	1.53	1.65	1.63	1.40	1.43
	(.70)	(.48)	(.67)	(.67)	(.52)	(.50)	(.49)	(.51)	(.66)	(.66)	(.56)	(.73)
8	1.56	1.67	1.71	1.73	1.72	1.84	1.85	1.77	1.68	1.75	1.50	1.50
	(.66)	(.79)	(.76)	(.84)	(.52)	(.95)	(.78)	(.68)	(.65)	(.72)	(.57)	(.57)
9	1.79	1.41	1.68	1.39	1.63	1.47	1.76	1.47	1.39	1.47	1.50	1.30
	(.77)	(.57)	(.55)	(.61)	(.49)	(.72)	(.82)	(.51)	(.56)	(.57)	(.57)	(.54)
10	2.09	1.41	1.54	1.48	1.63	1.59	1.68	1.71	1.71	1.63	1.67	1.40
	(.79)	(.50)	(.51)	(.76)	(.49)	(.76)	(.68)	(.71)	(.64)	(.61)	(.71)	(.62)
11	2.50	1.67	2.14	1.85	2.06	2.00	2.12	2.00	2.23	1.88	2.24	1.80
	(.99)	(.48)	(.59)	(.67)	(.67)	(.84)	(.64)	(.67)	(.72)	(.79)	(.83)	(.71)
12	2.53	1.89	2.18	1.76	2.19	2.06	2.38	2.00	2.10	2.03	2.27	1.77
	(.86)	(.75)	(.55)	(.75)	(.59)	(.85)	(.70)	(.74)	(.60)	(.69)	(.83)	(.50)

TABLE 16--Continued

Item #	State Office	Districts 1	2	3	4	5	6	7	8	9	10	11
13	2.62	1.56	2.04	1.94	1.94	2.00	2.18	1.83	1.81	1.77	1.90	1.73
	(.89)	(.58)	(.74)	(.93)	(.62)	(.88)	(1.11)	(.79)	(.83)	(.85)	(.80)	(.69)
14	1.62	1.59	1.46	1.70	1.34	1.84	1.82	1.67	1.71	1.78	1.70	1.90
	(.65)	(.69)	(.51)	(.73)	(.55)	(.68)	(.97)	(.80)	(.78)	(.71)	(.77)	(.71)
15	1.79	1.70	1.82	1.67	1.91	1.34	1.97	1.93	1.42	1.47	1.90	1.67
	(.88)	(.82)	(.77)	(.82)	(.73)	(.60)	(.87)	(.83)	(.56)	(.72)	(.55)	(.80)
16	3.12	3.52	3.39	2.73	3.28	3.34	2.76	3.03	3.23	3.00	3.47	3.07
	(.91)	(.70)	(.88)	(1.13)	(.85)	(.79)	(1.13)	(1.10)	(.72)	(.98)	(.62)	(.98)
17	3.47	3.19	3.00	3.18	3.34	3.38	3.26	3.27	3.45	3.28	3.23	3.33
	(.66)	(.68)	(.98)	(1.01)	(.70)	(.71)	(.86)	(.83)	(.62)	(.85)	(.86)	(.92)
18	1.59	1.89	1.54	1.76	1.34	1.97	1.71	2.13	2.06	1.69	1.60	1.63
	(.61)	(.97)	(.79)	(.90)	(.70)	(.74)	(.84)	(1.20)	(1.03)	(.82)	(1.07)	(.61)
19	1.53	2.04	1.68	2.00	2.21	1.38	2.12	1.83	1.52	1.84	1.87	1.77
	(.56)	(.94)	(.61)	(1.09)	(.75)	(.75)	(.84)	(.87)	(.77)	(.95)	(.57)	(.82)
20	3.24	2.74	3.21	3.33	2.78	3.00	2.62	2.70	3.06	2.94	3.23	2.90
	(.70)	(1.23)	(.79)	(.85)	(.83)	(.80)	(.92)	(.95)	(.73)	(.88)	(.97)	(.96)
21	3.65	3.33	3.34	3.24	3.72	3.50	3.47	3.53	3.68	3.47	3.10	3.70
	(.49)	(.68)	(.83)	(.87)	(.52)	(.67)	(.93)	(.68)	(.65)	(.88)	(.84)	(.47)
22	2.15	1.67	1.89	1.88	1.75	2.03	2.44	2.27	2.35	2.00	2.50	1.77
	(1.10)	(1.04)	(1.07)	(.96)	(.98)	(1.00)	(1.11)	(1.31)	(1.14)	(1.08)	(1.31)	(1.07)
23	2.38	2.52	1.96	2.09	2.22	1.88	2.29	2.40	2.00	2.19	2.13	2.57
	(1.04)	(.89)	(.88)	(1.10)	(.91)	(.98)	(.76)	(1.07)	(1.18)	(.82)	(1.08)	(.86)
24	2.41	2.41	2.54	2.82	2.38	2.53	1.91	2.13	2.68	2.47	2.57	2.30
	(1.04)	(1.15)	(1.10)	(1.21)	(.94)	(1.02)	(1.06)	(.94)	(.91)	(1.19)	(1.00)	(1.06)

TABLE 16--Continued

Item #	State Office	Districts 1	2	3	4	5	6	7	8	9	10	11
25	3.06	3.33	3.46	3.15	3.69	3.44	3.21	3.37	3.16	3.41	2.77	3.37
	(1.13)	(.78)	(.79)	(.87)	(.69)	(.76)	(1.01)	(.81)	(.97)	(.98)	(1.07)	(.89)
26	3.15	2.67	2.79	3.03	2.84	2.94	2.94	2.93	2.94	2.63	2.90	2.70
	(.66)	(.68)	(.57)	(.85)	(.68)	(.67)	(.55)	(.80)	(.57)	(.75)	(.61)	(.84)
27	2.41	2.73	2.64	2.79	2.66	2.88	2.56	2.46	2.81	2.78	3.00	2.60
	(.78)	(1.04)	(.78)	(1.02)	(.79)	(1.04)	(.93)	(.96)	(.87)	(.94)	(.72)	(1.04)
28	2.68	2.38	2.39	2.53	2.47	2.25	2.41	2.31	2.36	2.38	2.34	2.33
	(.77)	(.57)	(.74)	(.80)	(.62)	(.67)	(.66)	(.71)	(.66)	(.79)	(.77)	(.92)
29	3.09	2.92	2.86	2.85	2.81	2.44	2.38	2.73	2.77	2.88	2.97	2.53
	(.75)	(.84)	(.80)	(.87)	(.78)	(.95)	(.70)	(.74)	(.85)	(.94)	(.81)	(.78)
30	2.47	2.04	2.50	2.03	2.16	2.16	2.47	2.40	2.36	2.13	2.38	2.00
	(.86)	(.59)	(.75)	(.59)	(.68)	(.72)	(.66)	(.77)	(.49)	(.61)	(.73)	(.70)
31	2.52	2.30	2.20	2.33	2.19	1.94	2.41	2.43	2.19	2.16	2.28	2.17
	(.86)	(.78)	(.63)	(.65)	(.59)	(.72)	(.70)	(.77)	(.60)	(.72)	(.70)	(.79)
32	2.52	2.30	2.44	2.61	2.25	2.22	2.24	2.33	2.55	2.55	2.48	2.37
	(.82)	(.67)	(.64)	(.70)	(.62)	(.66)	(.65)	(.80)	(.51)	(.68)	(.74)	(.85)
33	2.79	2.70	2.79	2.72	2.66	2.50	2.65	2.77	2.67	2.74	2.38	2.70
	(.77)	(.61)	(.74)	(.85)	(.55)	(.72)	(.69)	(.73)	(.55)	(.77)	(.68)	(.79)
34	2.73	2.48	2.68	2.39	2.66	2.88	2.53	2.47	2.61	3.03	3.00	2.30
	(.84)	(1.05)	(.86)	(.90)	(.75)	(.75)	(.96)	(.94)	(.72)	(.74)	(.65)	(.92)
35	2.59	2.04	2.68	2.06	2.55	2.69	2.97	2.40	2.35	2.41	2.97	2.53
	(.99)	(.98)	(.77)	(.93)	(.77)	(.78)	(.87)	(.81)	(.80)	(1.07)	(.82)	(.97)
36	1.85	1.81	1.82	1.88	1.94	1.88	1.85	1.57	1.45	1.44	1.53	1.60
	(.66)	(.79)	(.82)	(.74)	(.84)	(.91)	(.78)	(.82)	(.51)	(.62)	(.57)	(.93)

TABLE 16--Continued

Item #	State Office	Districts 1	2	3	4	5	6	7	8	9	10	11
37	2.21	2.11	2.43	2.45	2.47	2.00	2.06	1.97	1.90	1.97	2.03	1.70
	(.84)	(.93)	(.88)	(.83)	(.76)	(.82)	(.65)	(.85)	(.54)	(.90)	(.81)	(.84)
38	1.76	1.81	1.68	1.94	2.03	1.75	1.91	1.57	1.68	1.66	1.63	1.53
	(.65)	(.79)	(.61)	(.70)	(.82)	(.80)	(.79)	(.63)	(.60)	(.70)	(.67)	(.68)
39	2.00	2.04	1.71	2.21	2.19	1.91	2.00	1.67	2.00	1.84	1.80	1.80
	(.82)	(.81)	(.66)	(.74)	(.82)	(.96)	(.78)	(.76)	(.73)	(.81)	(.71)	(.81)
40	1.85	1.93	2.15	2.03	1.94	1.84	1.82	1.67	1.58	1.53	1.50	1.73
	(.70)	(.83)	(.99)	(.77)	(.84)	(.85)	(.80)	(.84)	(.50)	(.72)	(.68)	(1.05)
41	2.62	2.35	2.39	2.59	2.48	2.28	2.47	2.10	2.26	2.19	2.13	2.14
	(.82)	(.75)	(.79)	(.80)	(.72)	(.77)	(.83)	(.90)	(.77)	(.78)	(.90)	(.95)
42	2.21	2.22	2.89	2.58	2.63	2.22	2.41	2.27	2.42	2.31	2.40	2.27
	(.98)	(.80)	(.79)	(.90)	(.75)	(.83)	(.82)	(.98)	(.67)	(1.03)	(.97)	(.87)
43	2.08	2.07	2.75	2.64	2.47	2.28	2.32	2.17	2.35	2.31	2.30	2.23
	(.90)	(.78)	(.80)	(.99)	(.76)	(.85)	(.73)	(1.02)	(.80)	(1.06)	(.92)	(.94)
44	2.35	2.11	2.61	2.50	2.56	2.13	2.38	2.17	2.10	2.03	2.24	2.03
	(.92)	(.64)	(.88)	(.92)	(.80)	(.75)	(.74)	(.99)	(.65)	(.91)	(.79)	(.93)
45	2.74	2.41	2.74	2.64	2.69	2.41	2.59	2.33	2.42	2.41	2.23	2.30
	(.83)	(.89)	(.81)	(.86)	(.74)	(.67)	(.78)	(.84)	(.56)	(1.01)	(.90)	(.88)
46	2.79	2.59	2.68	2.58	2.69	2.47	2.38	2.37	2.35	2.41	2.40	2.13
	(.77)	(.93)	(.86)	(.90)	(.78)	(.67)	(.78)	(.93)	(.71)	(.94)	(.81)	(.78)
47	1.68	1.96	2.00	1.45	2.16	1.72	1.50	1.87	2.00	1.81	1.63	1.60
	(.77)	(.76)	(.86)	(.62)	(.77)	(.68)	(.66)	(.90)	(.82)	(.93)	(.76)	(.72)
48	2.12	1.96	2.25	1.97	2.03	1.88	1.79	2.27	2.00	2.25	2.07	2.21
	(.73)	(.52)	(.75)	(.77)	(.74)	(.55)	(.48)	(.52)	(.58)	(.57)	(.58)	(.86)

TABLE 16--Continued

Item #	State Office	Districts 1	2	3	4	5	6	7	8	9	10	11
49	2.53	2.52	2.57	2.73	2.44	2.41	2.50	2.70	2.55	2.63	2.90	2.90
	(.79)	(.75)	(.84)	(.80)	(.72)	(.84)	(.79)	(.60)	(.62)	(.83)	(.76)	(.92)
50	2.09	2.11	2.43	2.55	2.25	2.19	2.29	2.47	2.10	2.44	2.37	2.50
	(.71)	(.85)	(.79)	(.79)	(.67)	(.69)	(.68)	(.63)	(.47)	(.72)	(.72)	(.86)
51	3.41	3.30	3.29	3.55	3.25	3.41	3.53	3.27	3.52	3.50	3.53	3.77
	(.66)	(.72)	(.66)	(.67)	(.72)	(.50)	(.51)	(.87)	(.68)	(.62)	(.68)	(.68)
52	2.53	2.81	2.96	2.30	3.91	2.81	2.85	2.57	3.06	2.35	2.70	2.10
	(.83)	(.74)	(.69)	(.77)	(.69)	(.64)	(.70)	(1.01)	(.81)	(1.05)	(.75)	(.96)
53	3.53	3.31	3.39	3.48	3.44	3.50	3.50	3.50	3.52	3.38	3.37	3.67
	(.51)	(.68)	(.57)	(.62)	(.50)	(.57)	(.51)	(.51)	(.68)	(.83)	(.67)	(.55)
54	2.45	2.33	2.39	2.27	2.16	2.25	2.24	2.33	2.42	2.32	2.39	2.30
	(.56)	(.68)	(.79)	(.57)	(.63)	(.67)	(.74)	(.71)	(.72)	(.54)	(.63)	(.84)
55	1.59	1.81	1.68	1.52	1.72	1.53	1.59	1.62	1.68	1.63	1.63	1.63
	(.50)	(.48)	(.55)	(.57)	(.52)	(.72)	(.56)	(.68)	(.48)	(.61)	(.49)	(.61)
56	2.88	3.11	3.00	2.94	2.88	3.19	3.00	2.97	3.16	2.81	2.87	2.73
	(.98)	(.70)	(.90)	(.90)	(.75)	(.74)	(.78)	(.96)	(.73)	(.91)	(.73)	(.98)
57	1.71	1.63	1.75	1.58	1.88	1.78	1.94	1.73	1.77	1.94	2.00	1.72
	(.58)	(.56)	(.65)	(.56)	(.49)	(.75)	(.74)	(.69)	(.50)	(.72)	(.74)	(.70)
58	2.53	2.74	2.36	2.58	2.63	2.88	2.85	2.90	2.65	2.75	2.77	3.00
	(.71)	(.71)	(.78)	(.71)	(.61)	(.71)	(.56)	(.71)	(.61)	(.57)	(.57)	(.83)
59	3.38	3.22	3.21	3.15	3.32	3.09	3.15	3.17	3.48	3.31	3.40	3.27
	(.55)	(.75)	(.74)	(.71)	(.54)	(.59)	(.61)	(.65)	(.63)	(.69)	(.56)	(.64)
60	3.15	2.78	2.93	3.09	2.93	2.81	3.15	3.00	3.13	2.88	3.13	2.77
	(.66)	(.80)	(.60)	(.81)	(.58)	(.54)	(.57)	(.71)	(.50)	(.71)	(.51)	(.73)

TABLE 17

SUMMARY OF F RATIOS FOR ONE-WAY ANALYSIS OF VARIANCE FOR QUESTIONNAIRE AND DEMOGRAPHIC ITEMS

Item Number	Demographic Category 1 Age	2 Sex	3 Race	4 Work Location	5 Education	6 Subject	7 Present Position	8 Years in Position	9 Training & Experience with Older Persons	10 Training & Experience in Counseling
1	0.66	0.32	0.14	0.99	0.62	1.57	1.62	0.94	1.49	0.94
2	1.37	3.45	11.97**	2.15*	4.81**	2.85**	8.09**	2.49*	0.48	0.23
3	1.21	0.33	1.65	1.30	0.86	0.72	2.13	0.56	4.07*	0.95
4	0.56	0.00	4.30*	2.54**	2.28*	1.42	2.45*	0.36	2.41	0.05
5	1.23	0.38	7.25**	2.44**	1.64	1.01	1.15	1.77	1.67	0.23
6	0.85	1.01	5.73*	2.04*	1.85	1.99	5.57**	1.19	1.06	0.84
7	2.76*	0.04	0.30	1.41	2.09*	1.57	0.45	1.70	1.10	4.25*
8	0.85	0.00	0.13	0.85	1.77	1.21	1.00	0.44	3.07*	8.20**
9	0.55	1.27	0.11	2.08*	4.01**	0.73	3.49**	0.42	0.63	2.37
10	0.43	0.57	0.08	2.41**	3.76**	1.17	10.10**	1.40	6.92**	1.65
11	0.86	0.13	0.41	2.98**	0.55	2.11*	3.72**	2.50*	3.52*	1.24
12	0.48	0.16	1.53	3.42**	1.28	2.79**	5.43**	1.28	1.32	2.36
13	0.75	0.03	5.39*	3.29**	2.87**	0.66	9.06**	0.80	0.94	1.19
14	1.37	3.23	0.16	1.87*	1.12	1.88	2.37	0.60	0.41	1.92
15	0.56	0.12	0.41	2.48**	0.78	1.48	2.90*	2.41*	0.52	3.31*
16	0.86	4.16*	1.46	2.43**	1.75	1.07	0.16	1.19	0.42	3.47*
17	1.46	0.60	27.76**	0.75	5.89**	1.19	1.85	0.49	3.02	4.50*
18	3.44**	2.00	5.93*	2.19*	1.71	1.19	0.69	0.53	1.32	0.61
19	2.95**	0.18	0.05	3.22**	1.42	0.54	3.06*	1.16	0.53	0.94
20	0.28	0.15	2.33	2.29*	0.88	0.90	1.23	0.69	1.72	3.30*

TABLE 17--Continued

Item Number	Demographic Category 1 Age	2 Sex	3 Race	4 Work Location	5 Education	6 Subject	7 Present Position	8 Years in Position	9 Training & Experience with Older Persons	10 Training & Experience in Counseling
21	1.75	0.00	0.43	2.20*	3.13**	0.60	3.81**	0.26	1.43	0.80
22	1.61	0.31	1.85	2.01*	2.98**	1.40	6.35**	1.03	5.36**	2.73
23	1.54	7.91**	0.00	1.60	0.80	2.05*	1.82	0.68	2.17	3.39*
24	1.44	3.39	0.58	1.67	1.92	1.69	0.98	0.56	0.13	3.21
25	0.93	0.39	0.87	2.07*	2.02	0.82	7.66**	2.12	4.05*	1.35
26	0.64	0.91	7.92**	1.55	3.23**	0.84	9.00**	2.98*	0.15	1.29
27	0.94	0.73	0.93	1.06	2.40*	1.51	3.13*	1.79	1.64	0.82
28	1.07	0.51	1.10	0.78	0.76	0.68	3.56**	0.81	0.22	0.23
29	1.43	0.67	0.88	2.22*	1.14	1.15	2.35	1.29	2.52	3.90*
30	2.07	0.16	4.71*	2.38**	1.07	1.33	3.56**	1.14	0.46	2.58
31	2.67*	0.21	3.80	1.55	0.57	1.65	2.03	1.37	0.08	2.46
32	0.65	0.09	2.11	1.43	0.10	1.65	1.38	2.35*	0.18	0.48
33	0.37	0.08	1.49	0.88	1.76	1.61	1.41	2.71*	0.38	1.12
34	1.56	0.21	0.02	2.31**	0.99	0.86	0.60	0.97	1.11	0.28
35	1.87	0.02	0.12	3.39**	2.59*	1.40	0.37	2.13	0.14	0.61
36	1.36	0.25	1.84	1.87*	6.04**	2.47*	1.88	1.06	15.90**	6.17**
37	0.53	0.11	0.21	2.71**	4.45**	2.84**	6.07**	1.40	7.02**	18.08**
38	0.43	0.01	0.51	1.47	3.95**	1.96	1.31	1.28	16.57**	3.37*
39	0.59	0.94	5.53*	1.49	3.87**	2.40*	2.23	1.07	12.48**	1.46
40	1.45	3.42	7.04**	1.88*	6.99**	2.47*	4.42**	0.32	4.76**	2.68

TABLE 17--Continued

Item Number	Demographic Category 1 Age	2 Sex	3 Race	4 Work Location	5 Education	6 Subject	7 Present Position	8 Years in Position	9 Training & Experience with Older Persons	10 Training & Experience in Counseling
41	0.93	0.32	0.00	1.52	2.51*	1.28	2.60*	0.88	5.77**	7.24**
42	1.24	1.78	0.11	1.66	4.63**	7.03**	2.65*	0.99	3.24*	41.69**
43	1.35	4.48*	0.06	1.58	6.08**	7.53**	3.58**	1.56	7.02**	53.23**
44	0.46	0.88	0.30	1.88*	3.49**	3.66**	1.73	2.01	6.87**	11.68**
45	0.83	0.25	0.32	1.43	2.52*	3.15**	2.29	0.79	13.37**	13.90**
46	0.77	0.64	0.71	1.55	1.05	2.51*	2.80*	0.99	7.76**	8.37**
47	2.20*	6.13*	0.17	2.55**	3.00**	2.61*	0.66	0.96	0.92	1.89
48	0.85	0.06	0.90	1.81	1.53	1.24	1.43	1.41	1.28	1.88
49	0.95	0.02	8.29**	1.37	1.65	0.69	2.19	0.62	1.24	0.27
50	3.61**	0.00	0.02	1.65	1.78	1.41	1.75	2.21	2.27	0.87
51	2.26*	0.14	9.06**	1.58	4.11**	2.50*	1.69	1.49	4.82**	3.41*
52	1.48	0.02	0.28	4.08**	2.23*	2.18*	1.75	1.66	0.24	4.39*
53	1.49	0.51	1.80	0.73	4.88**	2.77**	0.44	1.64	1.15	0.72
54	0.89	8.59**	4.09*	0.51	0.99	1.99	1.47	1.91	0.24	0.49
55	0.61	0.01	0.44	0.61	2.84**	0.81	0.09	1.05	9.70**	7.64**
56	0.91	1.16	25.62**	0.84	1.46	0.72	0.91	0.95	2.74	2.95
57	1.26	1.10	4.30*	1.25	2.38*	0.53	1.81	3.60**	1.08	2.32
58	5.73**	0.46	0.22	2.17*	1.63	1.89	1.57	1.03	3.52*	1.96
59	1.92	0.15	2.09	1.09	4.92**	1.44	1.80	1.11	0.83	1.44
60	0.66	0.69	9.76**	1.64	5.12**	1.39	5.94**	1.21	1.26	1.00

** $p < .01$
* $p < .05$

TABLE 16

PEARSON CORRELATION COEFFICIENTS BETWEEN DEMOGRAPHIC ITEMS AND QUESTIONNAIRE ITEMS

Item Number	Demographic Category 1 Age	2 Sex	3 Race	4 Work Location	5 Education	6 Subject	7 Present Position	8 Years in Position	9 Training & Experience with Older Persons	10 Training & Experience in Counseling
1	-0.04	0.03	-0.03	0.00	-0.04	-0.02	-0.11*	-0.03	0.08	0.06
2	-0.10*	-0.08	-0.16**	0.12**	0.22**	-0.14**	-0.25**	-0.15**	0.02	-0.00
3	0.03	-0.03	-0.09*	0.07	0.12*	-0.07	-0.03	-0.02	0.07	0.06
4	0.00	0.00	-0.10*	0.11*	0.15**	-0.08	-0.03	-0.03	0.03	-0.00
5	-0.08	-0.04	-0.13**	0.09*	0.13**	-0.07	-0.07	-0.13**	0.02	0.03
6	-0.05	-0.05	-0.12**	0.15**	0.08	-0.10*	-0.19**	-0.05	0.03	0.07
7	0.10*	0.01	0.04	0.01	-0.10*	-0.01	-0.05	0.13**	0.07	0.14**
8	0.05	0.00	-0.01	-0.09*	-0.15**	0.08	0.10*	0.03	0.12**	0.20**
9	0.04	0.06	-0.01	0.01	-0.12**	0.02	-0.15**	-0.01	0.05	0.09*
10	0.02	-0.03	0.03	0.14**	-0.04	0.05	-0.24**	-0.09*	0.03	0.09*
11	0.07	-0.01	-0.03	0.13**	0.03	-0.01	0.15**	0.10*	0.02	0.03
12	0.01	0.02	-0.07	0.10*	0.07	-0.02	-0.21**	-0.11**	0.05	0.04
13	-0.02	0.01	-0.12**	0.10*	0.15**	-0.04	-0.29**	-0.08	0.05	0.06
14	-0.12**	-0.09*	-0.01	0.06	0.07	-0.02	0.04	-0.02	0.01	-0.07
15	0.04	-0.02	0.03	-0.01	-0.09*	0.04	-0.04	-0.00	-0.05	-0.08
16	0.08	0.11*	0.06	-0.04	-0.05	-0.09*	-0.02	0.11*	0.04	0.13**
17	-0.04	-0.04	-0.27**	0.09*	0.28**	-0.02	-0.10*	-0.08	-0.12**	-0.15**
18	0.19**	-0.07	-0.12**	-0.02	0.03	0.01	0.03	0.00	-0.07	-0.06
19	-0.12**	-0.02	0.01	-0.11*	-0.10*	0.04	0.11*	-0.06	0.01	0.06
20	0.02	0.02	0.07	0.04	-0.02	-0.07	-0.11*	0.03	0.09*	0.12**

TABLE 18--Continued

Item Number	Demographic Category 1 Age	2 Sex	3 Race	4 Work Location	5 Education	6 Subject	7 Present Position	8 Years in Position	9 Training & Experience with Older Persons	10 Training & Experience in Counseling
21	-0.09*	-0.00	-0.03	0.08	0.19**	0.04	0.00	0.04	0.07	-0.07
22	0.04	-0.03	-0.09	0.11*	0.09*	-0.07	-0.15**	-0.04	-0.15**	-0.12*
23	-0.10	-0.14**	-0.01	0.06	0.06	-0.07	-0.02	-0.02	0.09*	0.10*
24	0.10	0.10	-0.04	-0.03	-0.11**	0.09*	-0.02	0.02	-0.01	0.01
25	0.02	0.03	0.07	-0.11*	0.02	0.06	0.24**	0.12*	0.14**	0.07
26	-0.05	-0.06	-0.14**	0.04	0.17**	-0.06	-0.27**	-0.12**	-0.03	-0.03
27	0.01	0.05	-0.06	-0.04	0.08	-0.00	0.11*	0.01	-0.07	-0.01
28	0.08	0.03	-0.06	0.04	0.02	-0.07	0.12**	-0.07	-0.02	0.03
29	-0.09*	0.04	-0.06	0.05	0.09*	-0.08	-0.04	0.05	-0.10*	-0.05
30	-0.01	-0.03	-0.10	0.05	0.06	-0.13**	-0.19*	-0.07	-0.04	0.03
31	-0.04	-0.03	-0.09*	0.04	0.06	-0.09*	-0.14**	-0.12*	0.01	0.03
32	0.04	0.01	0.06	0.07	0.02	-0.02	-0.09*	-0.11*	-0.01	0.03
33	-0.07	-0.04	-0.04	-0.02	0.13**	-0.06	-0.05	-0.07	-0.00	0.00
34	0.04	-0.03	-0.00	0.04	0.05	-0.05	-0.06	-0.04	-0.08	-0.02
35	-0.11*	-0.02	0.01	0.11*	0.08	0.03	-0.05	-0.14**	0.00	0.02
36	-0.00	0.03	0.08	-0.12**	-0.24**	0.11*	-0.07	-0.05	0.28**	0.18**
37	-0.03	0.01	0.03	-0.16**	-0.23**	0.16**	-0.07	-0.11*	0.19**	0.29**
38	-0.04	-0.01	0.05	-0.11*	-0.23**	0.08	0.01	-0.07	0.28**	0.29**
39	-0.02	-0.05	0.12**	-0.07	-0.22**	0.05	0.04	-0.09	0.24**	0.08*
40	0.03	0.09*	0.14**	-0.15**	-0.29**	0.14**	0.02	0.01	0.15	0.11*

TABLE 18--Continued

Item Number	Demographic Category 1 Age	2 Sex	3 Race	4 Work Location	5 Education	6 Subject	7 Present Position	8 Years in Position	9 Training & Experience with Older Persons	10 Training & Experience in Counseling
41	-0.06	-0.05	0.03	-0.04	-0.10*	0.11*	-0.09*	-0.9*	0.18**	0.19**
42	-0.01	0.07	-0.02	-0.11*	-0.26**	0.23**	0.08	-0.05	0.13**	0.42**
43	0.03	0.11*	0.00	-0.11*	0.30**	0.27**	0.07	-0.11*	0.19*	0.46**
44	-0.03	0.03	-0.00	-0.11*	-0.21**	0.20**	-0.01	-0.12*	0.19**	0.24**
45	0.06	-0.01	0.05	-0.05	-0.19**	0.15**	-0.02	-0.07	0.26**	0.26**
46	0.02	-0.04	-0.03	-0.07	-0.11*	0.07	-0.06	-0.04	0.20**	0.21**
47	-0.03	0.13**	0.03	-0.08	-0.20**	0.09*	0.08	0.10*	0.06	0.10*
48	0.06	0.01	-0.04	0.06	0.06	-0.12**	-0.01	0.10*	0.00	-0.10*
49	0.06	0.01	-0.14**	0.09*	0.07	-0.09*	0.05	0.03	-0.08	-0.01
50	0.23**	0.00	-0.00	-0.01	-0.09*	-0.09*	-0.00	0.14**	-0.10*	-0.04
51	-0.11*	-0.02	-0.16**	0.11*	0.18**	-0.10*	-0.03	-0.13**	-0.16**	-0.13**
52	-0.01	0.00	0.03	-0.15**	-0.11*	0.14**	0.09*	0.07	0.02	0.11*
53	-0.06	0.06	-0.07	0.09*	0.23**	0.04	-0.08	-0.09*	-0.07	-0.05
54	0.05	-0.12**	-0.09*	0.01	0.06	-0.00	-0.08	-0.12*	-0.03	-0.03
55	-0.02	0.00	0.03	-0.04	-0.21**	0.01	0.02	0.05	0.02	0.20**
56	-0.01	0.05	-0.27**	-0.09*	0.16*	0.03	0.01	-0.01	0.12*	0.08
57	0.04	-0.06	0.09*	0.05	-0.20**	0.00	-0.03	-0.14**	-0.04	0.05
58	-0.28**	0.04	0.02	0.08	0.04	0.06	0.08	-0.03	-0.11*	-0.02
59	-0.10	0.01	-0.08	0.11*	0.21**	-0.06	-0.04	0.06	-0.04	-0.07
60	-0.05	-0.04	-0.16**	0.07	0.24**	-0.05	-0.22**	-0.08	-0.04	-0.05

** $p < .01$
* $p < .05$

the Pearson correlation coefficients between demographic and questionnaire items.

Table 12 reports frequency of response choices, means, and standard deviation scores for the bulk of the survey items. The response means ranged from 1.51 to 3.47 and the range of standard deviations for these items was .57 to .92. Table 13 reports responses to those items that required subjects to rank order several factors. The mean responses to these items ranged from 1.66 to 3.48. The range of standard deviations was .73 to 1.12. Of the four priority service areas for older persons, transportation was rated as the greatest need by most respondents.

Table 14 summarizes response to those items related to understanding older persons and their needs as well as items assessing relationships of counseling theory and practice and service provision for older clients. The range of mean responses for these items was 1.72 to 2.49. Standard deviations ranged from .71 to .89.

Table 17 includes results of one-way analysis of variance based on questionnaire and demographic items. The greatest number of differences were found in the comparisons made on the basis of geographic location and job position, the two major variables used in selecting the sample. Twenty-nine signficaint F ratios were reported related to subjects' location and 24 were significant based on position. Additionally, 30 significant F ratios were found related to respondents' level of education. Other areas of major significance included experience and training in working with older persons and experience and training in counseling. There were several significant results in other

categories of demographic information; however, their incidence of occurrance was small.

Pearson correlation coefficients between demographic and questionnaire items yielded the results displayed in Table 18. Variables of particular significance occurred between areas such as job position, location, education, counseling experience and experience in working with older persons. The following discussions present these results in greater detail and draw on the information contained in Tables 12-18.

Analysis of Questionnaire Items

Each item (1-60) of the survey instrument is reviewed individually. Statistical results including mean, standard deviation, and response frequencies are reported. Other correlations or F ratios of significance are presented where appropriate.

Item 1. To what extent do you agree that this definition describes counseling and counseling activities with older persons?

The mean response to this item was 1.63 and the standard deviation was .59. As indicated in Table 12, only 4.5% of the subjects disagreed or strongly disagreed. By far, most subjects, 95.5%, were in agreement with the established definition's description of counseling services. Analysis by job position yielded the following range of mean scores: Specialized Adult Services (SAS), 1.57, to State Program Office (PDAA) at 1.79. The standard deviation of the SAS subgroup was among the lowest at .54 while the PDAA staff had the highest standard deviation at .77. When compared to the whole sample, scores for the SAS staff were six points less than the sample mean and the PDAA mean was 16 above the mean.

Table 16 reports mean responses by geographic location. Subjects in District 9 ($\bar{X}$ = 1.47), District 11 (1.50), and District 5 (1.53) were among the lowest means. PDAA staff had the highest mean response, that of 1.79. Again, it is noted that answers of strongly agree or agree to this item were given scores of one or two, respectively, on the Likert Scale.

None of the ANOVA's reported for Item 1 were significant (Table 17). One correlation, that of subject's position and Item 1, was significant at -0.11 ($p < .05$) as shown in Table 18. Responses were increasingly in agreement with the definition as position varied from administrative to direct service jobs.

Item 2. To what extent do you agree that counsleing services as currently provided in HRS Aging and Adult Services programs are consistent with this definition?

The sample mean response to this question was 2.35 with a standard deviation of .73. Of all subjects, 8% reported SD, 26.9% D, 57.7% A, and 7.4% SA. Thus, more than half (65.1%) of those responding indicated agreement that current provision of counsleing services is within the scope of the present definition of counseling.

Breakdown by job position (Table 15) yielded a range of mean scores from a low of 2.20 for SAS staff to 2.79 for PDAA personnel. Standard deviations were .62 for SAS, to .84 for both PDAA and Areawide Agency on Aging (AAA) workers. As compared to the whole sample, the PDAA and AAA staff standard deviations were 11 points higher and the SAS standard deviation was 11 points lower.

Responses as categorized by location showed District 5 at 2.10, District 2 at 2.15 and District 10 at 2.25 as among the lowest means. As in Item 1, the PDAA subgroup was most variable in its responses with

a SD of .84. Among the least variable were District 10 (.50), District 8 (.57) and District 4 (.58).

Six significant ANOVA scores were found for question two. At the .01 level, race (11.97), position (8.09), education (4.81) and educational area (2.85) were significant. Other variables significant at .05 were years in present position (2.49) and work location (2.15). In addition, seven of the ten demographic variables were found to be significantly correlated with this item and these are noted in Table 18.

Item 3. To what extent do you agree that the following services can be considered as "counseling" according to the definition given above: Legal Counseling?

The mean response to this item was 2.14 with 71.7% of subjects indicating either agreement or strong agreement. A standard deviation of .80 was computed for this question. Subgroup responses ranged from 2.44 (PDAA) to 1.98 (AAA). District Program Office staff and project staff yielded mean scores of 2.14 and 2.06, respectively. When compared by geographic location, subjects in District 7 averaged the highest responses (2.73) while those in District 3 reported the least agreement with this item.

Analysis of variance procedures yielded one significant F ratio between demographic characteristics and question 3. At the .05 level, a score of 4.27 was found with subjects indicating they had some training or experience in working with older persons. Two significant correlation coefficients were found between Item 3 and race (-0.09) and education (0.12), both at .05 level. Mean responses for males (2.18) and females (2.12) were similar, as noted in Appendix N.

Item 4. To what extent do you agree that the following services can be considered as "counseling" according to the definition given above: Tax Counseling?

The mean response for all subjects to this item was 2.47 with a standard deviation of .77. Slighly more than half of the respondents were in disagreement or strong disagreement that tax counseling is included in the given definition of counseling (50.4%). A breakdown by job position yields a range of mean responses of 2.71 (PDAA) to 2.31 (Project staff). In terms of geographic location, personnel in District 1 averaged a response of 1.96 while those in District 8 scored 2.74. State Program Office staff averaged their responses at 2.71.

Several significant F ratios resulted from the analysis of variance on question 4. Race (4.30 at .05), work location (2.54 at .01), and present position (2.45 at .05) were significant. Significant correlation coefficients included race (-0.10 at .05), work location (0.11 at .05), and education (0.15 at .01). Males and females produced the same mean response (2.47) to this question.

Item 5. To what extent do you agree that the following services can be considered as "counseling" according to the definition given above: Investment Counseling?

Subjects responding to this item averaged 2.60 with a standard deviation of .80. Over half of those answering (57.3%) felt that this service did not fall within the established definition of counseling. When categorized by job position, project staff averaged lowest (2.53) and State Program Office staff highest (2.85). In terms of work location, mean responses ranged from 3.00 in District 8 to 2.19 in District 1.

As shown in Table 17, only one item yielded a significant result from the one-way ANOVA. Work location produced an F ratio of 2.44 (.01).

Sex and training or experience in counseling were the least significant items for Question 5. A number of meaningful correlations were noted, including the following: work location, 0.09 (.05), race, -0.15 (.01), education, 0.15 (.01), and years in current job position, -0.13 (.01). There was little difference in the average scores of males (2.64) and females (2.58) to this question.

Item 6. To what extent do you agree that the following services can be considered as "counseling" according to the definition given above: Budgeting?

The mean response to this item for the sample as a whole was 2.05 with a standard deviation of .75. As this score indicates, a large majority of participants (75%) believed budgeting to be a valid part of counseling services. More persons in the State Program Office (2.47) disagreed while those subjects in Specialized Adult Services (SAS) were most in agreement with the statement (1.87). As shown in Table 16, the range of mean responses by location was from 1.74 in District 1 to 2.47 (PDAA and District 11).

Two significant F ratios were reported, work location (2.04 at .05) and present job position (5.5 at .01). Several significant correlation coefficients were found, including race (-0.12 at .01), work location (0.15 at .01), education subject area (-0.10 at .05) and present position (-0.19 at .01). When reported in terms of educational level, mean responses ranged from 1.95 for subjects with four year degrees to 2.75 for those in the Other category.

Item 7. To what extent do you agree that the following services can be considered as "counseling" according to the definition given above: Mental Health Counseling?

The mean response to this item was 1.51, indicating an overall agreement that mental health services were considered by most subjects

to be included in the counseling definition. In total, 96.3% of those responding either agreed or strongly agreed with the statement. Breakdown by job position indicates, again, an overall similarity of response, with a range of 1.48 (SAS) to 1.60 (AAA). Greater variation was found when subjects were grouped by location, with a range from 1.55 in District 1 to 1.72 in District 4.

Two variables, age and education, produced significant results from the analysis of variance, as shown in Table 17. Four significant correlation coefficients were found, including: age (0.10 at .05), education (-0.10 at .05), years in job position (0.13 at .01), and counseling experience (0.14 at .01). Mean scores grouped by level of education showed highest agreement among subjects with Ph.D. degrees (1.00) and least among those with Ed.S. degrees (2.00).

Item 8: To what extent do you agree that the following services can be considered as "counseling" according to the definition given above: Marital Counseling?

Most respondents indicated a belief that this item is consistent with the established definition of counseling. The sample mean was 1.69 (standard deviation of .72) and 89.8% of those answering were in agreement. Responses grouped by job position ranged from 1.75 (SAS) to 1.56 (PDAA). Geographic location reponse means ranged from 1.50 (Districts 10 and 11) to 1.85 in District 6.

Two variables produced significant results from the ANOVA performed. Training and experience in counseling (8.20 at .01) and working with older persons (3.07 at .05) were significant. Work location, education, present job, training in counseling, and gerontology were all significantly correlated with responses to Item 8. Average responses for males and females were equal (1.69). Responses

varied somewhat by age (Appendix P), from 1.81 (56-60 years) to 1.35 (under 25 years).

Item 9. To what extent do you agree that the following services can be considered as "counseling" according to the definition given above: Social Service Counseling?

Subjects predominantly considered social service counseling services appropriately included in the larger definition. Mean response for the sample as a whole was 1.53 with 94.9% either agreeing or strongly agreeing. A standard deviation of .63 was found for this item. Grouping by job position yielded the following: 1.50 for SAS, 1.50 for District Program Staff, 1.53 for AAA, 1.60 for Project Staff, and 1.79 for PDAA. Geographic location categories showed District 11 in most agreement (1.30) and subjects in the State Program Office less so (1.79).

Work location, education, and present job position were variables found significant from the analysis of variance. Similarly, three demographic items (education, present position, and counseling background) produced significant correlation coefficients. Males' and females' mean responses were 1.47 and 1.55, respectively.

Item 10. To what extent do you agree that the following services can be considered as "counseling" according to the definition given above: Protective Services?

The group mean response to Question 10 was 1.63 with a standard deviation of .67. The largest group of subjects (91.7%) indicated agreement that protective services are within the scope of the counseling definition. Breakdown by job position yielded a range of average responses from 2.09 (PDAA) to 1.40 (SAS). Differences noted by geographic location ranged from 1.40 (District 11) to 2.09 in the State Program Office.

Analysis of variance yielded four significant results, including work location (2.41 at .01), education (3.76 at .01), present position (10.10 at .01), and experience or training in gerontology (6.92 at .01). Several demographic items were also found to be significantly correlated with this question. Work location (0.14 at .01), present position (-0.24 at .01), years in job (0.09 at .05), and counseling experience (0.09 at .05). Responses varied somewhat by level of education as well, ranging from 2.50 (Ph.D) to 1.50 (4 year degree and Ed.S. degree).

Item 11: To what extent do you agree that the following services can be considered as "counseling" according to the definition given above: Nursing Home Ombudsman?

Mean responses for those answering this question was 2.05, with 23.5% in strong agreement and 51.1% in agreement that this service is a component of counseling. State Program Office staff were in least agreement (2.50) and AAA and SAS personnel were most in agreement (1.98). State Program Office employees were also in least agreement when grouped by geographic location (2.50) and most supportive were subjects in District 1 (1.67).

Analysis of variance produced significant results for demographic variables of work location (2.98 at .01), educational subject (2.11 at .05), present position (3.72 at .01), years in position (2.50 at .05)., and training or experience in working with older persons (3.52 at .05). Significant correlation coefficients were found for work location (0.13 at .01), present position (0.15 at .01) and years in job (0.10 at .05).

Item 12. To what extent do you agree that the following services can be considered as "counseling" according to the definition given above: Consumer Education?

The mean response for the sample as a whole to this item was 2.10, with a standard deviation of .74. More than half the respondents, 72.6%, indicated they agreed or strongly agreed that consumer education services fall within the established definition of counseling. Specialized Adult Services staff were most in agreement with this statement (1.92) while workers in the State Program Office were least supportive (2.53). When grouped by geographic location, mean responses ranged from 1.77 in District 11 to 2.53 in the State Program Office.

Significant demographic items resulting from the ANOVA included work location (3.42 at .01), educational major (2.79 at .01), and present position (5.43 at .01). Significant correlations included work location (0.10 at .05), present position (-0.21 at .01), and years in position (-0.11 at .01).

Item 13. To what extent do you agree that the following services can be considered as "counseling" according to the definition given above: Information and Referral?

Information and referral services were considered by most participants to be a function of counseling. With a mean response of 1.95, 76.8% of those responding indicated either agreement or strong agreement. Subjects in the State Program Office were least inclined to consider this service a part of counseling (2.62) while SAS workers were most in agreement (1.71). The range of mean responses when grouped by location was 2.62 (PDAA) to 1.56 (District 1).

Four items were found significant from the analysis of variance procedures: race (5.39 at .05), location (3.29 at .01), education (2.87 at .01) and present position (9.06 at .01). Significant correlations were found for race, work location, education, and present position. As reported in Appendix P, when grouped by age, respondents

in the under 25 category were not in agreement (1.65) while those in the 46-55 age range (2.00) were least likely to agree with the statement.

Items 14-17. Please rank these services (transportation, home services, legal and other counseling, residential repair and renovation) according to which you feel are the most important (areas of greatest need) for older persons (1 = greatest need, to 4 = least need).

As noted previously, these four services constitute the areas of major national priority for federally funded aging programs. Mean responses to Items 14-17 resulted in the following ranking (most important to least important): transportation (1.66), home services (1.72), legal and other counseling services (3.15) and residential repair (3.29). There were notable differences between the percentages of subjects ranking the first two items as most important and the support given the last two. Questions 14 (transportation) and 15 (home services) produced 89.5% and 85.3%, respectively. Responses placed these two services as being most needed (combining greatest need and great need responses). By contrast, legal and other counseling services were considered in the greatest and great need categories by only 19.3% of respondents.

Responses varied by geographic location and no pattern was discernible for these questions based on location. Groupings by job position indicated that Project Staff were most supportive of transportation needs (1.52) while District Office staff were least supportive (1.81). Home services were ranked higher (1.56) by District Program staff than by Project staff (1.89). Mean responses by job position on Item 16 (legal and other counseling services) varied from 3.22 (AAA) to 3.11 (SAS). Item 17 (Housing Repair) produced a

range of mean rankings by job position from 3.47 (PDAA) to 3.17 (Project Staff).

Analysis of variance for Questions 14-17 produced several significant results. As reported in Table 17, sex, race, work location, education, present position, and previous training were notable variables associated with this section. Similar results were found in the significant correlation coefficients as reported in Table 18. Mean responses for males and females to Question 16 (regarding counseling services) were 2.99 and 5.21, respectively. When reported in terms of educational level, mean responses to Question 16 ranged from 4.00 (0-11 years) to 2.58 (A.A. degree).

Items 18-21. Please rank these areas (transportation, home services, legal and other counseling services, residential repair) according to which you believe are currently being provided with most emphasis in HRS Aging and Adult Services Programs in your area (1 = most emphasis; 4 = least emphasis).

Mean responses for those subjects answering these items produced the following ranking of these priority services in terms of perceived emphasis: transportation, 1.74; home services, 1.82; legal and other counseling services, 2.98; and residential repair, 3.48. As in the previous section, the first two services were believed to receive most emphasis by a much larger percentage of respondents than those who felt Items 20 and 21 were most stressed. Transportation was ranked highest by 48.8% of those responding to Question 18. To Item 19, home services, 41.0% rated this as receiving greatest emphasis. By contrast, only 9.1% of the respondants to Question 20 (counseling services) rated it as receiving greatest emphasis. Home repair was rated highest by 2.1% of those answering Item 21.

Mean responses by job position yielded the following extremes of scores. For Item 18 (transportation), means ranged from 1.59 (PDAA) to 1.89 (District Program Staff). The rating of home services, Item 19, produced a range of means from 1.53 (PDAA) to 1.98 (Project Staff). Rankings for Item 20 (counseling services) were from 2.87 (SAS) to 3.24 (PDAA). Item 21 (residential repair) had mean scores of 3.28 (Project Staff) to 3.65 (PDAA).

In terms of geographic location, subjects in District 4 rated Item 18 as receiving most emphasis while those in District 7 gave it least emphasis (1.34 and 2.13, respectively). Home services, Item 19, was most emphasized in District 5 (1.58) and least emphasized in District 4 (2.21). Counseling services were considered most emphasized in District 6 (2.62) while subjects in District 3 reported least emphasis on this priority (3.33). Finally, residential repair was reported most emphasized in District 10 (3.10), least in District 11 (3.70).

Analysis of variance for these items (18-21) yielded significant F ratios for age, race, location, education, position, and training in counseling. Work location was significant for each question in this section, as reported in Table 17. Pearson correlation coefficients produced significant relationships between these items and several demographic variables. Age, race, location, education, position, and training in counseling and gerontology were significant. As shown in Table 18, age was correlated significantly with items 18, 19, and 21. Item 20, which deals with counseling services, was found most highly correlated with present job position, and work or training in counseling and with older persons.

Items 22-25. Please rank these areas from one (1) to four (4) according to which you believe are the most easily provided to older persons (1 - most easily provided, 4 = most difficult to provide).

Group mean responses to this section produced the following ranking of services in terms of the ease with which subjects felt they are provided: transportation, 2.06; home services, 2.21, legal and other counseling services, 2.43; residential repair, 3.28,

Areawide Agency on Aging staff considered transportation more difficult to provide than did other job position groups, with a mean score of 2.73, while SAS staff felt it was easier to provide (1.81). Responses to Item 23, indicated a range of 1.87 (AAA) to 2.38 (PDAA) for home services. Subjects in District Program Offices indicated they felt counseling was more difficult to provide than did other job groupings (2.58 to 2.20 for AAA Staff). Residential repair, Item 25, produced a range of 2.92 for District Program Staff to 3.61 for SAS subjects. When considered by geographic location, no pattern of responses to Items 23 to 25 was noted. High and low rankings varied by District to each question and no single district produced more than one extreme score.

Analysis of variance yielded several items of significance to these four questions. Transportation (Item 22) was significant with work location, education, present position, and training in working with older persons. Item 23, home services, was significant with sex, educational subject, and training in counseling. Work location, present position, and training in working with older persons were significant with Item 25, residential repair. Specific values for these F ratios are reported in Table 17. No significant items were found for Question

24, legal and other counseling services. Pearson correlation coefficients were found significant with work location, education, present position, and training in counseling and gerontology with Question 22. Home services, Question 23, yielded significant correlations for sex and training or experience in counseling and working with older persons. Question 24, legal and other counseling services, was significantly correlated with education and educational subject major. Residential repair, Question 25, was significantly correlated with location, present position, years in position, and experience or training in working with older persons.

Item 26. To what extent do you agree that counseling needs of older persons served by HRS Aging and Adult Services Programs are currently being adequately met.

The sample as a whole produced a mean response of 2.88 to this question, indicating that the majority of subjects were in disagreement with the statement. Thus, 54.8% disagreed and 17.2% strongly disagreed that the counseling needs of older persons are currently being met by HRS programs. Respondents in District 9 were most in agreement (2.63) while those in the State Program Office were least supportive of the statement (3.15). When grouped by job description, SAS staff were most in agreement (2.70) while those in District Program Offices were least supportive (3.22).

Analysis of variance for Question 26 indicated race (7.92 at .01), education (3.23 at .01), present position (9.00 at .01), and years in position (2.98 at .05) were associated with this question. Race (0.14 at .04), education (0.17 at .01), present position (0.27 at .01), and years in position (-0.12 at .01) were significantly correlated with responses to this item.

Item 27. To what extent do you agree that better quality, more comprehensive counseling services can be provided with existing funding and staff levels than those currently being provided within the aging network?

Most respondents indicated disagreement with this statement, with a mean score of 2.69. Over half, 58.4%, either disagreed or strongly disagreed with the statement that better quality services can be provided with existing resources. In terms of job position, SAS staff were least supportive, 2.90, while subjects in the State Program Office were not in agreement (2.41). Responses from District 10 were most negative (3.00) and those from the State Program Office most supportive when grouped by location.

Two items, education and present position were found significant from the ANOVA. Only one factor, present position, was found to be significantly correlated with the question. Males and females responded similarly, 2.62 and 2.70, respectively. A difference was noted in responses by level of education, from 2.00 (Ph.D. and other) to 3.00 (0-11 years).

Item 28. To what extent do you agree that counseling services currently available in HRS Aging and Adult Services programs are providing significant assistance to older persons?

A slight majority of participants was more in agreement than not with this statement, with a mean score of 2.41. Combining agree and strongly agree responses, 59.1% of the subjects answering believed current services are providing significant assistance to older persons. Only 7.0% strongly disagreed with this item. Responses grouped by location were fairly uniform with a range of 2.68 (PDAA) to 2.25 (District 5). Job position produced a similarly even response pattern with mean scores ranging from 2.26 (SAS) to 2.68 (PDAA). Only one item

was found significant from ANOVA: present position, with an F ratio of 3.56 (at .01). Present job position was also the only item found significant from the correlation done (0.12 at .01). Males and females tended to respond the same as well, 2.36 and 2.42, respectively.

Item 29. To what extent do you agree that counseling services currently available through community mental health centers are providing significant assistance to older persons?

Responses to this item were fairly evenly divided between agree and disagree choices, with 34.7% and 39.5% selecting each, respectively. Mean response for the sample as a whole was 2.77 with a standard deviation of .85. Answers by job position ranged from 2.09 (PDAA) to 2.63 (Project Staff). A limited range of responses was found when grouped by location with a high of 3.09 (PDAA) and a low of 2.38 (District 6).

Analysis of variance for Item 29 yielded two significant items, work location (2.22 at .05) and training or experience in counseling (3.90 at .05). Three items were significantly correlated: age, education, and training or experience in working with older persons. Specific values for these correlations are reported in Table 18. Little difference was found between male and female mean responses, 2.71 and 2.79, respectively.

Item 30. Counseling services currently available are providing significant assistance to older persons in their attempts to avail themselves of existing transportation.

The majority of respondents agreed that counseling services are currently facilitating older persons' efforts to obtain transportation. Of the whole sample, 58.3% agreed with the statement and 10.2% strongly agreed. The mean response for the total group was 2.26, with a standard deviation of .70. Responses by location varied from 2.00 (District 11) to 2.50 (District 2). Responses by job position ranged

from most agreement among SAS subjects (2.11) to least support from District Program Office staff (2.50).

Analysis of variance yielded only two items of significance, work location (2.38 at .01) and present position (3.56 at .01). Likewise, two items were significantly correlated, educational subject, (-0.13 at .01) and present position(-0.19 at .01). Males and females produced mean responses of 2.28 and 2.25, respectively.

Item 31. Counseling services currently available are providing significant assistance to older persons in their attempts to avail themselves of existing home services.

A large majority, 60.8%, of those answering this question were in agreement that counseling does assist the elderly in obtaining home services. Only 4.6% strongly disagreed with this statement and the overall mean response was 2.26. Males and females were very similar (2.29 and 2.25, respectively) in their answers. Differences by location ranged from 2.53 (PDAA) to 2.15 (SAS). A greater difference was found when responses were compared by location. Mean response varied from 1.94 (District 5) to 2.52 (PDAA). Only age (2.67 at .05) was significant from the ANOVA. However, four items were found to be correlated with Question 21: race, educational subject, present position, and years in position.

Item 32. Counseling services currently available are providing significant assistance to older persons in their attempts to avail themselves of existing legal and other counseling services.

A slight majority (50.3%) of respondents indicated agreement that current services do facilitate older persons access to counseling services. The mean response for the whole sample to this item was 2.41. A sizable percentage (37.0%) disagreed with the statement. There was

little variability across job positions, with a high mean response of 2.62 (PDAA) and a low of 2.32 (SAS). The range of mean scores categorized by geographic location was 2.22 in District 5 to 2.62 in the State Program Office.

Analysis of variance results yielded only one significant item, years in current job position (2.35 at .05). Similarly, two items were found to be correlated with Question 32. Present position and years in present position were significant with values of -0.09 and -0.11 (at .05) respectively. Very little difference was found between male (2.43) and female (2.41) mean responses.

Item 33. Counseling services currently available are providing significant assistance to older persons in their attempts to avail themselves of existing residential repair and renovation.

Mean responses to this item were fairly evenly split between agree and disagree choices, with 39.6% and 46.3%, respectively. Average group response was 2.67, with a standard deviation of .71.

Little difference was noted between job groupings with State Program Office staff in most disagreement (2.79) and Project Staff most agreeable (2.56). Males and females responded similarly as well, 2.69 and 2.67, respectively. A larger range of mean responses was found with geographic differences. State Program Office personnel and those in District 2 were least supportive of the statement (2.79) while subjects in District 10 were most in agreement. Only one item, education (0.13 at .01) was found correlated, and one item, years in position, was found significant through ANOVA.

Item 34. Publicly funded counseling services should be provided only in existing AAS Programs or in community mental health centers to maximize benefits for older persons.

The mean sample response to this item was 2.65. The largest percentage (45.8%) of subjects disagreed with this statement and only 10.8% were in strong support of it. Responses by job position ranged from 2.56, SAS, to 2.75, District Program Staff. A greater range was found in terms of location. Subjects in District 9 were most in disagreement, 3.03, and those in the State Program Office were most supportive, 2.73. No items were found to be correlated with Question 34, and only one, work location, was significant from the analysis of variance.

Item 35. Counseling services for the elderly should be provided primarily by existing AAS programs (rather than community mental health centers) in order to maximize access to such services for older persons.

Most responses to this item indicated disagreement with the statement (44.7%). Approximately one-fourth of the subjects (25.6%) expressed agreement. The mean sample response was 2.52, with a standard deviation of .92. Responses grouped by job position ranged from 2.46, SAS, to 2.62, AAA. Location means ranged from 2.04 (District 2) to 2.97 (Districts 6 and 10). Three items were found significantly correlated: age, location, and years in present position. Two F ratios were found significant, location and education. Males and females responded similarly, 2.53 and 2.52, respectively.

Item 36. Please evaluate the level of your knowledge concerning needs of older persons.

Mean response to Item 36 was 1.72. Most subjects felt at least adequately prepared in this area. A large percentage (87.2%) responded that their preparation was either comprehensive or adequate. Only 3.2% indicated inadequate levels of knowledge concerning the needs of the elderly. Males (1.69) felt slightly more prepared than did females

(1.73). Subjects in the State Program Office indicated poorest background (1.85), while direct service providers in SAS believed they were best prepared (1.60). Geographic differences ranged from 1.94 (District 4) to 1.44 (District 9). A number of significant correlation coefficients were found, including location, education, subject, and training in counseling and working with older persons. Two items, location and education, were significant through ANOVA. Specific values for these results are found in Tables 17 and 18.

Item 37. Please evaluate the level of your knowledge concerning counseling needs of older persons.

Again, most respondents (43.3%) indicated adequate levels of knowledge concerning the counseling needs of the elderly. Mean sample response was 2.11, with a standard deviation of .83. One-fourth of the responses, 25.0%, indicated that those subjects assessed their level of preparation as comprehensive. Only 4.3% felt inadequately skilled. Responses categorized by job position ranged from 1.83 (District Program Office staff) to 2.35 (Project Staff). Location means ranged from 1.70 (District 11) to 2.47 (District 4). Significant correlations included location, education, subject, years in position, and training in counseling and gerontology. Significant F ratios included location, education, subject, present position, and training or experience in counseling and working with older persons.

Item 38. Please evaluate the level of your knowledge concerning characteristics of older persons.

Only a small percentage, 1.3%, of subjects felt inadequately knowledgeable about the characteristics of older persons. The majority, 39.7% -- comprehensive, 46.9% -- adequate, evaluated their knowledge at a high level. The mean sample response was 1.75. Differences by location

ranged from 2.03 in District 4, to 1.53 in District 11. Staff responses varied from the District Program Staff, 1.58, to 1.85 for the Project Staff. Three items were found to be significant through the analysis of variance: education, training or experience in counseling, and training or experience working with older persons. These same three items and location were also found to produce significant correlation coefficients as well.

Item 39. Please evaluate the level of your knowledge concerning the process of aging.

The mean sample response, 1.94, indicated that most subjects felt adequately prepared or better in their knowledge of the processes of aging. Those indicating adequate or comprehensive levels combined equalled 77.0% of the total sample. Those in District 11 (2.04) felt least prepared and those in District 2 (1.71) indicated highest level of knowledge. District Program Office staff (1.64) believed they were most prepared and those on Project Staffs felt least knowledgeable about aging processes. Four significant correlation coefficients were found with Question 39: race, education, and training or experience in counseling and in gerontology. Significant results from the analysis of variance included race, education, academic subject, and training in working with older persons.

Item 40. Please evaluate the level of your knowledge concerning services available for older persons.

The mean response to this item, 1.80, was the highest in terms of level of knowledge on the questionnaire items. By far, most subjects felt they had adequate or comprehensive levels of knowledge concerning services for the elderly, 40.9% and 43.3%, respectively. Only 11.3% indicated limited knowledge and 4.6% indicated inadequate preparation. Variation of response by job position produced the following means: 1.85 (PDAA),

1.56 (District Program Office), 1.53 (AAA), 2.01 (Project Staff), and 1.73 (SAS). Range of response by location was 1.50 in District 10, to 2.15 in District 2. Significant correlation coefficients included sex, race, education, location, academic subject, and counseling training or experience. Analysis of variance also produced a number of significant items including race, location, education, subject, present position, and experience or training in working with older persons. Some difference was noted in mean responses for males (1.67) and females (1.84).

Item 41. Please evaluate the level of your knowledge concerning impact of counseling services on quality of life of older persons.

Responses were fairly evenly divided between adequate and limited levels of knowledge on this topic, 39.7% and 37.8%, respectively. Mean response for the entire sample was 2.34, with a standard deviation of .82. State Program Office staff indicated the most inadequate level of knowledge (2.62) while subjects in the District Offices felt most prepared (2.11). Similarly, categorization by location indicated lowest knowledge levels among State Program Office staff and highest in District 11. Six items were significantly correlated with Question 41, and four items were found to be significant from the ANOVA (see Tables 17 and 18).

Item 42. Please evaluate the level of your knowledge concerning counseling theory.

Subjects were about equally divided between adequate (37.0%) and limited (36.2%) levels of knowledge of counseling theory. Mean response was 2.40, with males, 2.30, and females, 2.44. Subjects in the District Program Office rated themselves best prepared and those in Project Staff positions felt least knowledgeable in this subject area. Breakdown by location revealed highest levels in the State

Program Office and those least knowledgeable in counseling theory were in District 2. Five items, location (-0.11 at .05), education (-0.26 at .01), subject (0.23 at .01), and training/experience in counseling (0.42 at .01), and gerontology (0.13 at .01) were significantly correlated. Education, subject, present position, and training or experience in counseling or working with older persons were significant from the analysis of variance.

Item 43. Please evaluate the level of your knowledge of counseling techniques.

The mean response for the sample to this item was 2.33. Choices were divided between adequate (39.1%) and limited (36.2%) preparation. Comprehensive level of knowledge was selected by 18.8% and 9.9% felt inadequately skilled in counseling techniques. Project Staff (2.55) were least knowledgeable and District Program Office subjects felt more prepared in this field. Other direct service providers, the SAS Staff, indicated a mean response of 2.27. Those in District 1 (2.07) and in District 2 (2.75) produced the extremes in mean response, in terms of location. A large number of demographic items, seven, were correlated with this question. Education, subject of education, present position, and training/experience in counseling or gerontology were found to be significant in the analysis of variance.

Item 44. Please evaluate the level of your knowledge in counseling concerns of older persons.

Most subjects felt adequately prepared in this area (43.5%), while only 7.3% indicated inadequate levels of knowledge. Mean response was 2.27, with a standard deviation of .84. A large number, 30.8%, felt only a limited level of knowledge about counseling concerns of the elderly, and 18.4% indicated comprehensive skills in this area.

District Program Office staff indicated the highest level of competency in this field, 2.03, while SAS staff, 2.19, and Project Staff, 2.38, felt the least prepared. Subjects in Districts 9 and 11 indicated most knowledge, and those in District 2 appeared least knowledgeable. Significant correlation coefficients were found for location, education, subject, years in present position, and training/experience in counseling and in working with older persons. Knowledge of the elderly's counseling concerns was found significant through the ANOVA with education and subject, and work/training in counseling and gerontology. Males (2.20) and females (2.30) differed somewhat in their mean responses.

Item 45. Please evaluate your level of knowledge concerning older persons' understanding of their attitudes about counseling services.

Most subjects indicated limited knowledge of this aspect (41.9%), while 36.6% felt adequately prepared. The mean group response was 2.49. District Program Office staff were most knowledgeable (2.20) and State Program Office staff least skilled (2.74) in this area. Those in District 10 felt best prepared (2.23) and State Office Staff and those in District 2 (2.76) were least knowledgeable. Four items were significant from the analysis of variance: education (2.52 at .05), subject (3.15 at .01), and training/experience in counseling (13.90 at .01) and in working with older persons (13.37 at .01). Significant correlation coefficients included education (-0.19 at .01), subject (0.15 at .01), counseling experience (0.26 at .01) and experience with older persons (0.26 at .01).

Item 46. Please evaluate your level of knowledge concerning older persons' perceptions and attitudes about counselors.

Of those responding to this item, 37.8% indicated limited knowledge; 40.2%, adequate knowledge; 11.0%, comprehensive preparation; and 11.0% inadequate preparation in this area. The mean response to the question was 2.49, with a standard deviation of .83. When subjects were grouped by current job position, District Program staff indicated the highest level of knowledge at 2.22, and State Program Office staff the least, at 2.79.

By location, District 11 staff felt most knowledgeable, at 2.13, and State Program Office staff the least, at 2.79. Analysis of variance produced four significant F ratios: educational subject (2.51 at .01), present position (2.80 at .01), experience/training in counseling (8.37 at .01) and experience/training in working with older persons (7.76 at .01). Significant correlation coefficients included three items: education (-0.11 at .05), experience/training in gerontology (0.20 at .01) and counseling (0.21 at .01).

Item 47. To what extent do you agree that professionally trained counselors are needed to provide adequate counseling services for older persons.

Most subjects strongly agreed (43.4%) that the statement was true; 37.3% indicated agreement. Only 1.6% strongly disagreed with the item. The mean group response was 1.77, one of the lowest reported. Range of mean response by job position was 1.68 (PDAA) to 1.86 (SAS). By location, 1.60 (District 11) and 2.16 (District 4) was the range. Five items were significantly correlated with Question 27: sex, education, subject, years in position, and experience/training in counseling and in working with the elderly. Analysis of variance was significant with age (2.20 at .05), sex (6.13 at .05), location (2.55 at .01), and education (3.00 at .01). Some difference 1.61 and 1.84, respectively, was noted between male and female mean responses.

Item 48. To what extent do you agree that trained paraprofessionals can provide adequate counseling services for older persons.

Mean response for the sample as a whole to this item was 2.06, with a standard deviation of .66. By far, most subjects indicated agreement (63.2%) with the concept of paraprofessional counselors. Only 2.2% of those responding strongly disagreed with the statement. Responses by job position varied from 1.96 (Project Staff) to 2.17 (District Program Staff). Respondents in Districts 2 and 8 had mean scores of 2.25 and those in District 6 were most in agreement (1.79). Significant correlation coefficients were educational subject (-0.12 at .01) and years in position (0.10 at .05). Analysis of variance did not produce any significant items.

Item 49. To what extent do you agree that trained volunteers can provide adequate counseling services for older persons.

Most responses were evenly divided between "agree" and "disagree," with 40.5% and 41.0%, respectively. The mean group response was 2.61. Project Staff were most supportive of this idea (2.46) and AAA staff were least in agreement (2.71). By location, subjects in Districts 10 and 11 were least in agreement (2.90) and those in District 5 were most in agreement. Three significant items from the correlation analysis were race, location, and educational subject. The ANOVA yielded one significant F ratio (8.29 at .01) for race.

Item 50. To what extent do you agree that trained peer counselors (other older persons) can provide adequate counseling services for older persons.

The majority of those answering (54.4%) were in support of the use of peer counselors in working with older persons. Only 2.31% strongly disagreed with this concept. Thirty percent disagreed and 9.4% strongly agreed. For the sample as a whole, the mean response

was 2.31. Areawide Agency on Aging personnel were most in disagreement with the statement (2.44) and State Program Office staff were most supportive (2.09). Location grouping again placed State Office subjects most in agreement, and those in District 3 least supportive. Significant correlation coefficients were developed for five items, and analysis of variance produced one significant F ratio. Males and females had the same mean response (2.31).

Item 51. To what extent do you agree that no specialized education/ training is needed to provide adequate counseling services for older persons.

Mean group response was 3.45, indicating one of the highest levels of disagreement reported. The standard deviation was .67. Over 53.1% of those answering indicated strong disagreement with the idea that no special training is needed to provide counseling for the elderly. Only 1.6% felt strong agreement, and 65.4% agreed with the statement. Males and females were similar in their responses (3.47, males; 3.44, females). By job position, mean responses ranged from 3.35 for the Project Staff to 3.61 for the District Program Staff. The range in terms of location was 3.77 (District 11) to 3.25 (District 4). Analysis of variance yielded six significant F ratios (Table 17) and eight significant correlation coefficients (Table 18).

Item 52. To what extent do you agree that persons functioning as counselors for older persons should be professionally trained and licensed to insure provision of adequate counseling services for older persons.

Of those responding, 54.6% disagreed that licensure and professional training were necessary. Those who agreed or who strongly agreed totaled 33.3% of the total sample. Mean group response was 2.66, and 12.1% indicated strong disagreement. Responses grouped by

job position ranged from 2.77 (SAS) to 2.42 (AAA). By location, District 11 was most supportive and District 9 the least in agreement (2.10 and 3.06, respectively). Significant correlation coefficients included education, location, subject, present position, and training/ experience in counseling. Analysis of variance yielded significant values in location, education, subject, and experience/training in counseling. Little difference was noted between male and female responses.

Item 53. To what extent do you agree that no specialized training in needs and characteristics of older persons is needed in order to provide adequate counseling services for the elderly.

Mean group response to this item was 3.47 with a standard deviation of .60. By far, most subjects disagreed or strongly disagreed (45.2% and 51.3%, respectively) with the statement. Only 12.6% strongly agreed that no special training in these aspects of gerontology was needed in order to provide adequate counseling to older persons. Mean responses by job position were uniformly negative, with a range of 3.43 (SAS) to 3.56 (District Program Office). In terms of location, subjects were also in disagreement with the item, ranging from 3.31 (District 1) to 3.67 (District 11). Significant correlations were found for three items: location, education, and years in position. Analysis of variance yielded two significant values: location (4.88 at .01) and education (2.77 at .01).

Item 54. To what extent do you agree that professional counselors functioning as District Level Staff consultants can train existing direct service staff to adequately provide counseling services for older persons.

Mean response to this item was 2.32 and most subjects were in agreement (61.8%) that counselor-consultants can adequately train

others to work with the elderly. In the extreme response categories, 6.0% strongly agreed and 5.7% strongly disagreed. District Program Office Staff were most opposed to the question (2.78) and SAS staff most supportive. Subjects in District 4 (2.16) were most in agreement while those in the State Program Office (2.45) agreed least. Three items yielded significant correlation coefficients: sex (-0.12 at .01), race (-0.09 at .05), and years in position (-0.12 at .05). Analysis of variance was significant for sex (8.59 at .01) and race (4.09 at .05). Males (2.49) and females (2.26) varied somewhat in their responses.

Item 55. To what extent do you agree that, by helping staff to focus on older persons as human beings, counseling services can enhance the effectiveness of all other services for older persons.

The overall mean response to this statement was 1.63, indicating a high level of agreement. Most respondents were in agreement (55.4%) and 40.9% strongly agreed. Only 0.3% strongly disagreed with this concept. Responses by job position ranged from 2.22 (SAS) to 2.45 (PDAA) and, by location, from 1.81 (District 1) to 1.52 (District 3). Analysis of variance yielded significant values for education (2.84 at .01), training/experience in counseling (7.64 at .01), and training/experience in working with older people (9.70 at .01). Items found to have significant correlation coefficients included education (-0.21 at .01) and training/experience in counseling (0.20 at .01).

Item 56. To what extent do you agree that counseling services should be provided solely as a separate and distinct rather than an integral part of other existing service programs for older persons.

The majority of respondents indicated disagreement with the statement (52.5%), and the mean group response was 2.96. Only 14.2% agreed that counseling should be provided as a separate service.

Responses varied little by job position, as shown in Table 15. In terms of location, the range of mean responses was from 2.73 in District 11 to 3.19 in District 5. Analysis of variance resulted in only one significant value (25.62 at .01) for race. Four items were significantly correlated with Question 56. These included race, location, education, and training/experience in working with older persons.

Item 57. To what extent do you agree that counseling services should be carried out as a part of all other HRS services for older persons.

The mean group response was 1.79, indicating strong support for the integration of counseling into other HRS services for the elderly. Most responses, 56.7%, were in the agree category, and 1.1% were in strong disagreement. Analysis of variance produced three items of significance: race (4.30 at .05); education (2.38 at .05); and years in position (3.60 at .01). Significant correlation coefficients were found for race (0.09 at .01), education (-0.20 at .01), and years in position (-0.14 at .01). Range of mean responses by job position was from 1.90 (Project Staff) to 1.70 (SAS). Location groupings ranged from 2.00 in District 10 to 1.58 in District 3.

Item 58. To what extent do you agree that older pesons are more effective counselors with their peers than are younger persons functioning as counselors for older persons.

Most subjects disagreed with this statement; 59.5% indicated that they did not believe age-peer counselors were more effective than younger persons in working with the elderly. The mean response for the sample to this item was 2.72. Less than one-third of the total were in agreement with the concept, with 27.1% agreeing and 4.8% strongly agreeing. Differences noted by job description ranged from 2.53 (PDAA) to 2.81 (District Program Staff and SAS). In terms of location,

subjects in District 11 were most in disagreement, 2.00, and those in District 2 the most supportive with a mean response of 2.36.

Analysis of variance for this question yielded three significant F ratios including age (5.73 at .01); location (2.17 at .05); and training or experience in working with older persons (3.52 at .05). Significant correlation coefficients were reported for these items: age (-0.28 at .01); and work or training with older persons (-0.11 at .05). Males and females responded somewhat differently, with mean scores of 2.68 and 2.73, respectively.

Item 59. To what extent do you agree that community mental health centers are currently meeting the counseling needs of older persons in your service area.

The mean response to this item for the sample as a whole was 3.26, indicating that most subjects disagreed. Of those responding, 53.0% selected the disagree choices. Only 0.3% strongly agreed and 9.9% agreed that mental health centers were currently meeting the counseling needs of older persons. Those strongly disagreeing comprised 36.8% of the whole. Responses grouped by job description were uniformly negative, ranging from 3.31 in District Program Offices to 3.15 among Project Staff. A similar response pattern was noted when viewed by geographic region. Respondents in District 5 were most in agreement, 3.09, while those in District 8, 3.48, agreed least.

Analysis of variance procedures yielded significant values for only one item; education (4.92 at .01). Correlation coefficients were found significant for two items; location (0.11 at .05) and education (0.21 at .01). Males (3.24) and females (3.27) responded similarly. A greater variation in response was noted when subjects were grouped by level of education. The range of mean responses to this variable was from

4.00 for those with Ed.S. degrees to 2.98 for those with 0-11 years of schooling.

Item 60. To what extent do you agree that HRS Aging and Adult Services programs are currently meeting the counseling needs of older persons in your service area.

The group mean response to this item was 2.98, suggesting that most respondents viewed HRS Aging Programs as deficient in meeting the counseling needs of older persons. The largest percentage of responses fell into the disagree, 61.2%, or strongly disagree categories, 19.2%. Only a small group, 1.4% strongly agreed with the statement, while 18.2% indicated agreement. Males and females differed slightly with mean responses of 3.03 and 2.97, respectively. In terms of job position, SAS staff responded with a mean of 2.81, while those in District Program Offices responded with a mean of 3.28. The range of mean responses by location varied from 2.77 in District 11 to 3.15 in the State Program Office.

From analysis of variance, significant values were found for the following items: race (9.76 at .01); education (5.12 at .01); and present job position (5.94 at .01). Correlation coefficients were significant for three items also: race (-0.16 at .01); education (0.24 at .01); and present position (-0.22 at .01). Response patterns on the basis of education yielded a range of mean scores from 2.00 (0-11 years) to 3.75 (Ed.S. degrees). When subjects were grouped by age, the range of average response was from 3.12 for under 25 years to 2.50 for those in the 71-80 age category.

Item 61. What specific counseling needs do you believe older persons have which are not currently being met by existing counseling programs (such as grief counseling, employment counseling, leisure counseling, family counseling, or drug counseling)? Please list:

To this open-ended question, a large variety of responses was made. All 373 subjects commented that some additional counseling services are needed by older persons. Responses were categorized into two subgroups on the basis of location: those in the Districts and those in the State Program Office. Several subjects added narrative comments as well as listing other counseling needs. These comments might best be summarized in the words of a social worker from District IV:

> Adequate counseling is rare--the Mental Health Center does not know the client and his/her needs or problems. HRS/AAA staff are not well trained and don't have time due to over-work, staff cuts, paperwork, etc. Most needed are leisure, mental health and personal growth counseling.

Reportedly unmet counseling needs, each listed by less than ten subjects, could be included in the following categories: home safety, insurance, sex, crime, understanding bureaucracy, taxes, assertiveness, ethics, retirement, home management, religion, legal aid, and financial aid. These areas were apparently considered as being marginally met by current programs and services.

Listed counseling needs, each of which were mentioned by from 10-50 subjects, were financial, physical health, alcohol abuse, personal growth, death, legal aid, reality orientation, adjustment, leisure, anxiety, and understanding the aging process. Items receiving most support among subjects included the following: death, drugs, family, grief, employment, leisure, and health counseling needs. Specific counseling needs were emphasized by the number of subjects indicated: employment, 60; family, 68; drugs, 83; nutrition, 89, leisure, 92; and grief counseling, 118.

CHAPTER 5

SUMMARY, DISCUSSION AND CONCLUSIONS, IMPLICATIONS, AND SUGGESTIONS FOR FURTHER RESEARCH

Summary

The purpose of this study was to determine the perceptions held by employees of HRS Aging and Adult Services Programs towards counseling services for older persons. An understanding of the relative importance these subjects gave to counseling in relation to other services was sought. Differences in these attitudes towards counseling among aging program administrators and direct service providers were investigated.

Subjects were selected form state program office personnel in Tallahassee and from each of the 11 HRS Districts throughout Florida. Major groups of subjects included Areawide Agency on Aging staff, District Program Office staff, Project staff, Specialized Adult Services staff, and State Program Office staff. The total number of subjects selected was 414 and 373 actually participated in the study.

The review of pertinent literautre revealed that no adequate instruments existed with which to measure attitudes towards counseling services for the elderly. There were some instruments available to assess attitudes towards aging, towards older persons, and towards counseling; however, none of these was adequate for the purposes of this research. Consequently, the researcher developed and field tested a

questionnaire designed to assess the attitudes of administrators and workers in programs for the aged towards counseling services for older persons.

The instrument was then administered to the selected sample by the researcher or by his representatives at selected work sites. Results were collected and analyzed by the procedures outlined in Chapter III. The resulting responses and statistical analyses are reported in Chapter IV. The following discussion relates these results to the research questions and conclusions are drawn from these data. Implications resulting from the research are also discussed.

Discussion and Conclusions

The item by item analysis of the information provided by the research instrument is summarized in Tables 12-18 and Appendices N-Q. References are made to these tables throughout this discussion.

The purpose of this study was guided by the five research questions related to the subjects' perceptions of counseling services for older persons. This discussion centers on relating the collected data to these questions and on the resulting conclusions which may be drawn.

Research Question 1 asked: How do the subjects define counseling and how do they differ in their definitions? Items 1-13 of the questionnaire related to this question. As shown in Table 12, most respondents agreed with the definition of counseling as defined by Florida guidelines. Direct services workers were more in agreement than any other group of subjects. Respondents in the State Program Office (PDAA) were least supportive of this definition. This

difference is particularly interesting in light of the fact that the State Program Office staff has major responsibility for the development of the definition itself. Few differences were noted when responses were compared by location or sex of subjects. The items relating to the services which can be considered as part of counseling received mixed responses from most subjects. Most participants agreed that legal, budgeting, mental health, marital, social service, protective service, nursing home ombudsman, consumer education, and information and referral services all fell within the parameters of the larger definition of counseling. Only two items, tax counseling and investment counseling, received a sufficiently negative response to be omitted as counseling functions.

These results are of interest because of the confusion over definitions of counseling and what it involves. Although mean responses to items 3-13 varied somewhat (from 1.51 to 2.60) most subjects did tend to assume a liberal interpretation of the definition. There is an apparent need to make a clearer distinction between counseling to resolve social and emotional problems or adjustment needs and services which are primarily informational or of a social service nature.

Research Question 2 asked: How did subjects perceive the role of counseling and of counselors in aging programs, and did they differ in their perceptions? Questionnaire items 47 through 60 sought clarification about subjects' perceptions of the positions counselors should occupy in programs for the elderly, what roles they should assume, the importance of training, and the status of counseling services within the overall aging program in Florida. Responses to these items produced some of the greatest differences in perceptions noted in the study. Overall,

it appears that HRS aging program workers favor an integration of counseling services within other programs rather than their separation, as a distinct service component (Items 55, 56, 57). This perception was relatively constant across job categories and few differences were noted between responses of administrators and direct service providers to this concept. In terms of the role of counselors, most respondents were in agreement that trained professional counselors are needed. At the same time, most agreed, but not strongly so, that paraprofessionals, age peers, or volunteers could adequately fulfill the counselor's role (Items 48, 49, 50). It is interesting to note that Project Staff, those with the least educational attainment, were most in agreement with the use of paraprofessionals. Of interest is the fact that subjects in this category are most likely to fall under the paraprofessional designation themselves. However, when subjects were grouped by educational level, those persons with the highest educational attainment were also most supportive of paraprofessionals and volunteers as counseling providers. Respondents holding two-year degrees were less supportive of this viewpoint.

With regard to the role of mental health centers in meeting the counseling needs of older persons, most respondents felt strongly that mental health programs were not meeting these needs. This response should be of particular importance to program planners who tend to view mental health centers as the main source of counseling services for the majority of publicly supported clients. This tendency is dramatically demonstrated by the level of funding provided for counseling services based in mental health centers as compared with funding of such services in other programs. Yet, only 0.3% of

participants in this study strongly agreed that mental health programs were meeting the counseling needs of older persons. Integration of counseling into the existing aging program network would appear to be a logical alternative rather than to isolate it in centralized mental health facilities. In addition, respondents agreed that professionally trained counselors are needed to provide adequate counseling services for older persons. They agreed also that paraprofessionals could serve a useful role.

Research Question 3 asked: How did subjects perceive counseling in relation to other services provided in programs for older persons and how did they differ in their perceptions? Items 14-25 of the questionnaire asked subjects to rank the major service components in relation to counseling. As noted in Chapter IV, legal and other counseling services were ranked third overall by those responding to these items. As might have been expected, Project Staff were most in favor of transportation services, since they perceived transportation as being the most acute of older persons' practical problems. As the researcher has noted, transportation needs are common to all age groups, particularly in rural areas, as well as to older persons. Since the various job classifications differed little in the ranking given to counseling, responsibilities in the organizational structure do not seem to influence attitudes toward counseling in relation to the other priority services.

When counseling was viewed in terms of what subjects believe to be the reality of existing levels of service, the same order of ranking occurred. Respondents were consistent in their evaluations. As transportation was considered most important, so it was perceived to be

receiving most emphasis in actuality. Similarly, there was a considerable difference between attitudes toward the first two priority services, transportation and home service, and toward the second two, legal and other counseling and residential repair and renovation. Attitudes toward legal and other counseling services produced a large range of mean scores when classified by job position. As in the case of Question 2, direct service providers (SAS and Project Staff) appeared more supportive of counseling while those in the State and District Program offices seemed to be less supportive.

When subjects were asked to rank the four priority services in terms of the ease with which they can be provided, the same ordering occurred. However, the mean scores for transportation, home services, and legal and other counseling services were clearly grouped. A greater difference appeared between the responses for these three services and for the lowest ranked service, housing repair.

When subjects were grouped by job classification, no consistent pattern of response was discernible in the ranking of the four services. In the use of transportation and legal and other counseling services, the direct service respondents tended to score at the extremes of the range as compared with the administrative staff. However, the Areawide Agency on Aging staff considered the transportation service more difficult to provide than did direct service providers. This situation is of interest as the SAS and Project staff are the workers who must deal most directly with the problems of transporting elderly clients. Mean responses were less varied for ratings of the ease of providing legal and other counseling services. A greater difference was found in the range of responses to the other two, namely home services and housing repair.

In the case of Research Question 3, it appears that the sample overall was fairly consistent in its ratings of the four priority services. Legal and other counseling services were not considered as a great a need by any of the subject groups. Several factors may have been involved. First, the pairing of legal and other counseling services may have created an impression among respondents that the services in question pertained primarily to legal assistance. And, second, because many older persons need transportation in order to avail themselves of other services, this need may have seemed basic to obtaining other services.

Research Question 4 concerned subjects' evaluation of the current status of counseling services being provided by HRS programs. Questionnaire items 26-35 focused on this topic. As presented in Chapter IV, responses to this section in general indicated a low level of agreement with these items. Relatively few subjects strongly agreed or strongly disagreed in their evaluations. Although it has been shown that counseling services were not considered a high priority, the majority of subjects disagreed with the statement that current programs are adequate to meet counseling needs. Direct Service staff (SAS, Project Staff) were more in agreement that counseling needs are being met than were program administrators. In terms of funding for counseling services, it is particularly significant that State Program Office staff and District Program Office staff tended to agree that current funding levels were adequate. Direct service providers, those who must actually work with the older clients, were strongly in disagreement with this conclusion. Although subjects were fairly evenly divided between those who agreed and those who disagreed that counseling

services can be provided within existing funding and staff levels, the majority did agree (Item 28) that current programs are providing significant assistance to older persons. There was little variation in mean response to this item when subjects were considered by job classification. Although subjects felt existing services were having a noticeable impact on meeting counseling needs, they apparently felt that additional funds and staff are needed in order to improve the quality of services.

When subjects were grouped by job position, extremes of response differences were noted to the statement that community mental health centers are providing significant assistance to older persons. Direct service providers were generally more supportive of mental health services that provide counseling to the elderly. However, State Office Staff, those responsible for administration and program planning, were most in disagreement with this statement.

Subjects in general agreed that counseling services currently facilitate older persons' access to other services such as transportation, home services and legal services. Little difference was noted among the responses to these items dealing with transportation and counseling services (numbers 30 and 32), when subjects were grouped by job title. The response that counseling was helping older persons obtain access to other services might be interpreted as support for the concept that counseling assistance should be integrated throughout aging programs, rather than confined to one component or location. This view was further strengthened by the subjects' responses to Items 34 and 35, which concern the integration of counseling services with aging programs. Most subjects disagreed that counseling be limited to only one program. This view was uniformly upheld by each of the sample sub-groups.

In summary, responses to items related to Research Question 4 indicated several attitudes towards the current level of counseling services. While most felt the counseling needs of the elderly were not adequately met, they did tend to feel current programs are providing meaningful assistance. Responses also indicated support for a decentralized counseling approach that would be present in both Aging and Adult Services and Mental Health programs.

Subjects differed in their assessment of the adequacy of service and funding; program administrators tended to view current services more favorably than did direct service providers. It might be concluded that administrators would defend current levels of service since they are responsible for the planning and implementation of them. Administrators may also have been more knowledgeable of the overall, state-wide program concepts and functions, and this may have influenced their perceptions. Conversely, as direct service workers must do their best with existing funding and programs; their evaluations, therefore, could be influenced by examples of extreme need they see in individual clients. Also, the case worker's view is perhaps limited to his/her particular assignment or District; thus these subjects would have less basis of comparison for their responses.

Research Question 5 sought information on the levels of knowledge and training held by subjects with respect to counseling skills and gerontological background. Questionnaire items 36-46 dealt with these areas. To all items but one (45), responses by the entire sample indicated that respondents generally felt adequately prepared in the areas listed. Indeed, to almost half of the items in this section, a substantial percentage of the sample indicated an adequate level of

knowledge related to counseling and gerontology. Greater strength was noted in knowledge about the needs and characteristics of older persons. Subjects apparently felt they had somewhat less expertise in counseling knowledge and skills.

Sub-groupings by job position yielded some interesting differences in response to the items involved. No consistent pattern was noted in this section, as in others where extremes of response were generally found between direct service workers and State Program Office Staff. Responses to the items dealing with counseling skills were fairly uniform across job lines. In generaly, PDAA staff did indicate less preparation in counseling than other subjects. However, no other single group consistently reported a high level of ability in this area.

Knowledge about older persons was reported to be greater among direct service providers in most cases, but again the differences in mean scores were slight. It is of interest to note that Project Staff were frequently among those who considered themselves least prepared in knowledge of older persons and their needs. This finding is significant, as personnel in this group are largely responsible for much of the direct daily contact with older clients. Their responses were in contrast to those of SAS workers who generally reported the highest level of knowledge in this area.

When subjects were grouped by level of educational attainment, responses consistently showed that those with the most years of education rated themselves most knowledgeable on all items in this section. This finding was to be expected because those with higher educational levels were more likely to be employed in administrative positions. Administrators as a total group did not rate their level of

knowledge nearly so high. The low ratings of those with little education, however, was consistent with responses of the Project Staff subgroup. Many employees in the Project Staff subgroup have little formal education.

Evaluation of Research Question 5 suggests that additional training is needed for Project Staff particularly, and for others in Aging and Adult Services programs in general. The lower self ratings among program planners and administrators regarding knowledge of older persons and their counseling needs could be interpreted as influencing the lower assessment given to counseling services by these personnel. A limited knowledge of older persons' needs and/or of counseling skills could conceivably influence the importance given these services in program planning. It is of interest that SAS staff generally were most critical of existing counseling services and yet they frequently indicated the highest level of reported knowledge of counseling needs of older persons. It is suggested that these data and similar in-put from field staff should be considered by program administrators and planners when services are planned, funded, and implemented. The probability is that additional knowledge is needed at all levels.

Implications

The foregoing discussion of the five research questions suggests some general implications which can be drawn from the data.

First, the questionnaire was developed using the federal/state definition of counseling and the federal/state listing of priority services for older persons, in the exact language used in the statutes. As expected, subjects in all job categories responded in general

agreement with these federal/state mandates. These responses may have been influenced by the knowledge that funding is most readily obtained for services as defined by the statutes.

Second, it is important to consider that defining counseling as a separate service, yet by definition integral with legal services, might have limited its effectiveness in the opinions of subjects participating in this study. A more supportive position for counseling services for older persons might have been possible had counseling been included as a component of the so-called "life support" services, specifically transportation, meals, and homemaker programs. The integration of counseling with the "life support" programs appears to be the most reasonable approach to improvement of all programs. Counseling might well assume the role of facilitator for "life support" services in Florida's Aging Programs.

Third, it is imperative that counseling professionals and educators communicate directly with Aging professionals in order to increase awareness of the contributions counseling can make to programs for older persons. Field research, such as this study, should be conducted with aging program professionals so that the useful results of the counseling effort for older persons can be demonstrated. Counseling professionals and educators may find that the development of counseling services for older persons is facilitative to other existing programs provided for the elderly, and may well enhance acceptance and expansion of counseling services in Florida, and elsewhere.

Fourth, as was discussed earlier, direct service staff tended to view most of their work tasks as counseling. This tendency again focuses attention on the need for a better defined, yet flexible

conceptualization of the counseling function as a part of aging programs. As reported, only 21 of more than 220 projects throughout Florida indicated counseling as a program function. This may be due to program staff assuming that counseling is being done and not claiming credit for it.

Fifth, the need for counseling services in aging programs has been emphasized throughout the study. The question of what elements make up counseling, i.e., information-giving versus personal problem solving and development, should be addressed in the literature and ultimately clarified in federal and state statutes. With the current movement to change staff titles from "social worker" to "counselor," the issue of definition has become critical for professionally trained counselors concerned with the development of viable counseling programs for older persons.

Sixth, it is suggested that counselor education departments in Florida give more emphasis to training staff personnel working with and for older persons. The results of this study indicate a need at all aging program staff levels for additional training in counseling theory, technique, and practice. To a lesser degree, better understanding of the process of aging was indicated as a need.

Seventh, it is suggested that a higher proportion of older persons be employed in Aging programs, thus supporting a positive view of the abilities of older persons to function productively in society. This study reveals that 42.4% of those sampled were in the 25-35 year age range, while 6.7% were 61 years of age and older; the conclusion is that Florida's aging programs have not hired older persons in proportion to their numbers in the state's population. Should this suggestion be

acted upon, more older persons might then be trained as counselors to fill vacancies in aging programs.

Eighth, this study has demonstrated that there is a considerable need for provision of training in the areas of counseling and gerontology. As has been indicated, employees in aging programs by and large lack adequate preparation and/or experience in working with older persons. This situation seems to exist across job positions, among program administrators as well as direct service providers. This inexperience also holds true for training and skills in counseling. This research has shown that most of the training reported by subjects was that which they had received after becoming employed in their present job positions.

Counselor educators have a role in meeting this training need. It would seen reasonable to insure that all students in counselor training programs be given at least minimal exposure to gerontological counseling, because of increasing numbers of older persons whom all counselors should better understand and appreciate. For the immediate future, counselor educators should concentrate on developing and implementing comprehensive on-the-job training programs for current staff employed in aging programs.

Suggestions for Future Research

In terms of future research, this study provides a data base from which other investigations could be undertaken in several areas.

First, a greater, in-depth analysis of counseling functions in programs for older persons is needed. Such an analysis could focus on

both the planned or stated counseling components of aging programs and on those that are actually performed by employees.

Second, attitudes of workers in aging programs towards older persons should be assessed and correlated with the findings of this research.

Third, the study has also underscored the need for further exploration into practical gerontology and its relationship to training counselors for older persons.

Fourth, more research is needed in the study and development of skills, techniques, and methods which may be specifically applied to working with older persons.

Fifth, the study has shown that subjects differ in their assessment of who should or who can best provide counseling to older persons. There is a need for additional research to determine the characteristics and qualities of counselors that are most effective with the elderly.

Sixth, replication of this study in other states or areas should provide a basis for useful and needed comparisons and future planning in Aging programs.

Theories of aging, applied gerontology, and counseling can be augmented by the research results presented here. There is a need for the factual, data-based field research that this study provides, to add to and facilitate evaluation of theoretical conceptualizations in these areas. Traditional theories concerning the processes and functions of aging in our society have already undergone alterations recently (i.e., disengagement). It is expected that the research presented

herein will continue to facilitate this process of change and modification of theory.

In terms of gerontological counseling, this research has underscored the problems encountered in defining counseling and counseling services. Most respondents tended to consider any and all aging program components as parts of counseling services. This study has demonstrated that there is considerable confusion over definitions and what falls into the counseling realm. Concentrated efforts are needed to bring about a greater consensus of this issue. One cannot expect field staff to realistically identify counseling needs, to provide counseling services, or make referrals to counselors if the counseling profession itself does not make clearly and widely known the definitions and limits of its field.

This study has implications for job opportunities for counselors. It is apparent from the research results that most workers perceive considerable need for the kinds of assistance counseling can provide. Additionally, it is clear that, of the four nationally mandated services, counseling is currently receiving least emphasis in Florida. The lack of adequate training among all program personnel further emphasizes the need for trained gerontological counselors. Such counselors are currently needed to provide direct services to older clients, to serve as consultants for other field and supervisory workers, and as trainers or training consultants. Input from counselors is needed in program planning and administration at district and state levels. It is reasonable to expect that these current needs will be translated into significantly increased job opportunities for qualified gerontological counselors in the near future.

Finally, this research has immediate implications for those responsible for the funding, planning, and administration of programs for Florida's older population. It is hoped that administrative staff will make use of these data in the planning and implementation of significant counseling services for the elderly. The categorization of research data by district and job position should facilitate identification of staff and locations most in need of attention with respect to counseling services. Training needs can be determined and planned for, based on this research. Clearly, this and other applications of the study will result in an improved quality and quantity of counseling services for older persons. Above all, this study will hopefully lead to service programs which are more humanistic and more responsive to the needs of the older citizens of Florida.

APPENDIX A

QUESTIONNAIRE

DEAR PARTICIPANT:

THIS QUESTIONNAIRE IS PART OF A RESEARCH PROJECT STUDYING THE ROLE OF COUNSELING SERVICES IN FLORIDA'S HEALTH AND REHABILITATIVE SERVICES AGING AND ADULT SERVICES PROGRAMS. WE ARE INTERESTED IN LEARNING ABOUT THE PERCEPTIONS HRS PERSONNEL HOLD TOWARDS COUNSELING FOR OLDER PERSONS (PERSONS OVER 60) AND THEIR OPINIONS REGARDING THE RELATIONSHIP OF COUNSELING TO OTHER SERVICES CURRENTLY BEING PROVIDED FOR THE ELDERLY. THE RESULTS OF THE STUDY WILL BE USED TO HELP PLAN FUTURE SERVICES FOR OLDER PERSONS, IMPROVE CURRENT PROGRAMS, AND MEET STAFF TRAINING NEEDS.

AS AN HRS OR PROVIDER AGENCY EMPLOYEE WORKING WITH OLDER PERSONS, YOUR OPINIONS CONCERNING COUNSELING SERVICES FOR THE ELDERLY ARE VITALLY IMPORTANT. YOUR COOPERATION IS ESSENTIAL FOR THIS STUDY TO BE A SUCCESS, AND ULTIMATELY TO IMPROVE SERVICES FOR OLDER PERSONS. IT IS HOPED THAT THE RESULTS WILL BE OF BENEFIT TO HRS EMPLOYEES, LIKE YOURSELF, TO BETTER PERFORM THEIR DUTIES IN WORKING WITH OLDER PERSONS.

PLEASE BE ASSURED THAT YOUR ANSWERS ARE CONFIDENTIAL AND THAT YOUR IDENTITY WILL NOT BE KNOWN. THE RESULTS OF THE STUDY WILL BE REPORTED IN GROUP TERMS WITH NO INDIVIDUAL RESPONDENT IDENTIFICATION. RESULTS OF THE STUDY WILL BE MADE AVAILABLE TO ALL PARTICIPANTS. THE RESEARCHER WILL BE AVAILABLE TO ANSWER ANY QUESTIONS OF INDIVIDUAL

PARTICIPANTS. PARTICIPATION IS VOLUNTARY. YOUR COMPLETION OF THIS SURVEY AND THE FORM BELOW INDICATE YOUR CONSENT TO PARTICIPATE. YOU WILL NOT BE PAID FOR PARTICIPATING.

"I HAVE READ AND I UNDERSTAND THE PROCEDURE DESCRIBED ABOVE. I AGREE TO PARTICIPATE IN THE SURVEY AND HAVE RECEIVED A COPY OF THIS DESCRIPTION."

SUBJECT _____

WITNESS _____

THE INVESTIGATOR HAS EXPLAINED THE CONTENT OF THIS STATEMENT OF INFORMED CONSENT TO THIS SUBJECT IN DETAIL.

_____, INVESTIGATOR MILLEDGE MURPHEY
PROGRAM SUPERVISOR, AGING AND ADULT SERVICES
2002 N.W. 13th STREET, 3rd FLOOR
GAINESVILLE, FL 32601
PHONE SUNCOM 325-1145

THIS QUESTIONNAIRE IS PART OF A PROJECT DESIGNED TO STUDY THE ROLE OF COUNSELING SERVICES IN FLORIDA'S HEALTH AND REHABILITATIVE SERVICES AGING AND ADULT SERVICES PROGRAMS. COUNSELING SERVICES ARE DEFINED AS:

> ASSISTANCE IN RESOLVING SOCIAL, HEALTH, OR EMOTIONAL PROBLEMS THROUGH ESTABLISHMENT OF A THERAPEUTIC RELATIONSHIP, AND APPLICATION OF SKILLED INTERVIEWING, LISTENING, AND PROBLEM SOLVING TECHNIQUES. (FACT, 1978, p. 29).

WE ARE INTERESTED IN LEARNING ABOUT THE UNDERSTANDINGS PERSONNEL WORKING IN AGING PROGRAMS HAVE REGARDING COUNSELING SERVICES FOR OLDER PERSONS (PERSONS OVER 60) AND THEIR OPINIONS REGARDING THE RELATIONSHIP OF COUNSELING TO OTHER SERVICES CURRENTLY BEING PROVIDED FOR THE ELDERLY. THE RESULTS OF THE STUDY WILL BE USED TO HELP PLAN FUTURE SERVICES FOR OLDER PERSONS, IMPROVE CURRENT PROGRAMS, AND MEET STAFF TRAINING NEEDS.

AS AN HRS OR PROVIDER AGENCY EMPLOYEE WORKING WITH OLDER PERSONS, YOUR OPINIONS CONCERNING COUNSELING SERVICES FOR THE ELDERLY ARE VITALLY IMPORTANT. YOUR COOPERATION IS ESSENTIAL FOR THIS STUDY TO BE A SUCCESS, AND ULTIMATELY TO IMPROVE SERVICES TO OLDER PERSONS.

PLEASE BE ASSURED THAT YOUR ANSWERS ARE CONFIDENTIAL AND THAT YOUR IDENTITY WILL NOT BE KNOWN. THE RESULTS OF THE STUDY WILL BE REPORTED IN GROUP TERMS WITH NO INDIVIDUAL IDENTIFIED. PARTICIPATION IS VOLUNTARY, AND YOUR COMPLETION OF THIS SURVEY WILL BE THE INDICATION OF YOUR CONSENT TO PARTICIPATE.

IT IS IMPORTANT THAT YOU ANSWER EACH ITEM. THE QUESTIONNAIRE SHOULD TAKE ONLY A LIMITED AMOUNT OF YOUR TIME.

PLEASE GIVE ONE ANSWER TO EACH ITEM BY CHOOSING THE RESPONSE THAT BEST DESCRIBES YOUR CURRENT FEELINGS. IT IS YOUR FIRST IMPRESSION, THE IMMEDIATE "FEELING" ABOUT THE ITEMS, THAT IS IMPORTANT.

THANK YOU FOR YOUR ASSISTANCE AND COOPERATION.

INFORMATION FORM

THE FOLLOWING INFORMATION IS REQUESTED SO THAT WE CAN MAKE MEANINGFUL COMPARISONS AMONG AND BETWEEN THE GROUPS OF RESPONDENTS. PLEASE CIRCLE ONE RESPONSE FOR EACH QUESTION. FOR EXAMPLE

THE OLDER AMERICANS ACT WAS FIRST PASSED IN:

(A.) 1965

B. 1973

* *

1. AGE:

A. UNDER 25	D. 46-55	G. 71-80
B. 25-35	E. 56-60	H. OVER 80
C. 36-45	F. 61-70	

2. SEX:

A. MALE B. FEMALE

3. RACE:

A. CAUCASIAN B. ETHNIC MINORITY

4. WORK LOCATION:

A. DISTRICT I	E. DISTRICT V	I. DISTRICT IX
B. DISTRICT II	F. DISTRICT VI	J. DISTRICT X
C. DISTRICT III	G. DISTRICT VII	K. DISTRICT XI
D. DISTRICT IV	H. DISTRICT VIII	L. STATE PROGRAM OFFICE

5. EDUCATION:

A. COMPLETED GRADES 0-11	E. MASTERS DEGREE
B. HIGH SCHOOL GRADUATE	F. Ed.S. DEGREE
C. ASSOCIATE OF ARTS DEGREE	G. Ph.D. DEGREE
D. FOUR YEAR COLLEGE GRADUATE	H. OTHER (SPECIFY) _____

6. SUBJECT IN WHICH HIGHEST DEGREE WAS EARNED:

A. ADMINISTRATION	E. PSYCHOLOGY
B. COUNSELING	F. SOCIOLOGY
C. SOCIAL WORK	G. OTHER (SPECIFY) _____
D. GERONTOLOGY	

7. YOUR PRESENT POSITION TITLE:

A. STATE PROGRAM OFFICE STAFF
B. DISTRICT PROGRAM SUPERVISOR
C. DISTRICT PROGRAM SPECIALIST
D. AREA AGENCY ON AGING STAFF
E. PROJECT STAFF ADMINISTRATION
F. PROJECT STAFF SERVICE WORKER
G. SPECIALIZED ADULT SERVICES CASEWORK SUPERVISOR
H. SPECIALIZED ADULT SERVICES WORKER
I. OTHER (SPECIFY) _____

8. NUMBER OF YEARS IN PRESENT POSITION:

A. LESS THAN 2 YEARS
B. 2-5 YEARS
C. 6-10 YEARS
D. 11-15 YEARS
E. 16-25 YEARS
F. 26-35 YEARS
G. OVER 35 YEARS

9. SPECIAL TRAINING OR EXPERIENCE IN WORKING WITH OLDER PERSONS:

A. YES
B. NO

10. * IF YES, PLEASE DESCRIBE:

11. SPECIAL TRAINING OR EXPERIENCE IN COUNSELING:

A. YES
B. NO

12. * IF YES, PLEASE DESCRIBE:

EACH OF THE FOLLOWING STATEMENTS AND QUESTIONS EXPRESS A CONCERN REGARDING THE PROVISION OF COUNSELING SERVICES FOR OLDER PERSONS. TO THE RIGHT OF EACH STATEMENT ARE FOUR (4) RESPONSE CHOICES:

SA - STRONGLY AGREE D - DISAGREE

A - AGREE SD - STRONGLY DISAGREE

READ EACH STATEMENT AND CIRCLE THE RESPONSE WHICH MOST ACCURATELY DESCRIBES YOUR PRESENT FEELING TOWARD THE STATEMENT. PLEASE ANSWER EVERY ITEM, AND MAKE ONLY ONE RESPONSE FOR EACH STATEMENT.

* * * * * * * * * * * * * * * * * * * *

COUNSELING MAY BE DEFINED AS: ". . .ASSISTANCE IN RESOLVING SOCIAL, HEALTH, OR EMOTIONAL PROBLEMS THROUGH ESTABLISHMENT OF A THERAPEUTIC RELATIONSHIP, AND APPLICATION OF SKILLED INTERVIEWING, LISTENING, AND PROBLEM SOLVING TECHNIQUES."

1.	TO WHAT EXTENT DO YOU AGREE THAT THIS DEFINITION DESCRIBES COUNSELING AND COUNSELING ACTIVITES WITH OLDER PERSONS:	SA	A	D	SD
2.	TO WHAT EXTENT DO YOU AGREE THAT COUNSELING SERVICES AS CURRENTLY PROVIDED IN HRS AGING AND ADULT SERVICES PROGRAMS ARE CONSTANT WITH THIS DEFINITION:	SA	A	D	SD

TO WHAT EXTENT DO YOU AGREE THAT THE FOLLOWING SERVICES CAN BE CONSIDERED AS "COUNSELING" ACCORDING TO THE DEFINITION GIVEN ABOVE:

3.	LEGAL COUNSELING	SA	A	D	SD
4.	TAX COUNSELING	SA	A	D	SD
5.	INVESTMENT COUNSELING	SA	A	D	SD
6.	BUDGETING	SA	A	D	SD
7.	MENTAL HEALTH COUNSELING	SA	A	D	SD
8.	MARITAL COUNSELING	SA	A	D	SD

9.	SOCIAL SERVICE COUNSELING	SA	A	D	SD
10.	PROTECTIVE SERVICES	SA	A	D	SD
11.	NURSING HOME OMSBUDMAN	SA	A	D	SD
12.	CONSUMER EDUCATION	SA	A	D	SD
13.	INFORMATION AND REFERRAL	SA	A	D	SD

THE OLDER AMERICANS ACT OF 1965, AS AMENDED, MANDATES THAT PROGRAMS FOR OLDER PERSONS PROVIDE SERVICES IN FOUR (4) MAJOR AREAS:

TRANSPORTATION
HOME SERVICES
LEGAL AND OTHER COUNSELING
RESIDENTIAL REPAIR AND RENOVATION

PLEASE RANK THESE SERVICES FROM ONE (1) TO FOUR (4) ACCORDING TO WHICH YOU FEEL ARE THE MOST IMPORTANT (AREAS OF GREATEST NEED) FOR OLDER PERSONS (1 = GREATEST NEED: 4 = LEAST NEED):

14. ____ TRANSPORTATION

15. ____ HOME SERVICES

16. ____ LEGAL AND OTHER COUNSELING

17. ____ RESIDENTIAL REPAIR AND RENOVATION

PLEASE RANK THESE AREAS FROM ONE (1) TO FOUR (4) ACCORDING TO WHICH YOU BELIEVE ARE CURRENTLY BEING PROVIDED WITH MOST EMPHASIS IN HRS AGING AND ADULT SERVICES PROGRAMS IN YOUR AREA (1 = MOST EMPHASIS; 4 = LEAST EMPHASIS):

18. ____ TRANSPORTATION

19. ____ HOME SERVICES

20. ____ LEGAL AND OTHER COUNSELING

21. ____ RESIDENTIAL REPAIR AND RENOVATION

PLEASE RANK THESE AREAS FROM ONE (1) TO FOUR (4) ACCORDING TO WHICH YOU BELIEVE ARE THE MOST EASILY PROVIDED TO OLDER PERSONS (1 = MOST EASILY PROVIDED, 4 = MOST DIFFICULT TO PROVIDE):

22. ____ TRANSPORTATION

23. ____ HOME SERVICE

24. ____ LEGAL AND OTHER COUNSELING

25. ____ RESIDENTIAL REPAIR AND RENOVATION

TO WHAT EXTENT TO YOU AGREE:

26.	COUNSELING NEEDS OF OLDER PERSONS SERVED BY HRS AGING AND ADULT SERVICE PROGRAMS ARE CURRENTLY BEING ADEQUATELY MET:	SA	A	D	SD
27.	BETTER QUALITY, MORE COMPREHENSIVE COUNSELING SERVICES CAN BE PROVIDED WITH EXISTING FUNDING AND STAFF LEVELS THAN THOSE CURRENTLY BEING PROVIDED WITHIN THE AGING NETWORK:	SA	A	D	SD
28.	COUNSELING SERVICES CURRENTLY AVAILABLE IN HRS AGING AND ADULT SERVICE PROGRAMS ARE PROVIDING SIGNIFICANT ASSISTANCE TO OLDER PERSONS.	SA	A	D	SD
29.	COUNSELING SERVICES CURRENTLY AVAILABLE THROUGH COMMUNITY MENTAL HEALTH CENTERS ARE PROVIDING SIGNIFICANT ASSISTANCE TO OLDER PERSONS:	SA	A	D	SD

COUNSELING SERVICES CURRENTLY AVAILABLE ARE PROVIDING SIGNIFICANT ASSISTANCE TO OLDER PERSONS IN THEIR ATTEMPTS TO AVAIL THEMSELVES OF EXISTING:

30.	TRANSPORTATION	SA	A	D	SD
31.	HOME SERVICES	SA	A	D	SD
32.	LEGAL AND OTHER COUNSELING	SA	A	D	SD
33.	RESIDENTIAL REPAIR AND RENOVATION	SA	A	D	SD
34.	PUBLICLY FUNDED COUNSELING SERVICES SHOULD BE PROVIDED ONLY IN EXISTING AAS PROGRAMS OR IN COMMUNITY MENTAL HEALTH CENTERS TO MAXIMIZE BENEFITS FOR OLDER PERSONS:	SA	A	D	SD

35. COUNSELING SERVICES FOR THE ELDERLY SHOULD BE PROVIDED PRIMARILY BY EXISTING AAS PROGRAMS (RATHER THAN COMMUNITY MENTAL HEALTH CENTERS) IN ORDER TO MAXIMIZE ACCESS TO SUCH SERVICES FOR OLDER PERSONS: SA A D SD

PLEASE EVALUATE THE LEVEL OF YOUR KNOWLEDGE IN THE LISTED AREAS BY CIRCLING ONE OF THE FOUR (4) RESPONSE CHOICES TO THE RIGHT OF EACH STATEMENT.

COMP. (COMPREHENSIVE) ADQ. (ADEQUATE)
LIM. (LIMITED) INADQ. (INADEQUATE)

36. NEEDS OF OLDER PERSONS COMP. ADQ. LIM. INADQ.

37. COUNSELING NEEDS OF OLDER PERSONS COMP. ADQ. LIM. INADQ.

38. CHARACTERISTICS OF OLDER PERSONS COMP. ADQ. LIM. INADQ.

39. PROCESS OF AGING COMP. ADQ. LIM. INADQ.

40. SERVICES AVAILABLE FOR OLDER PERSONS COMP. ADQ. LIM. INADQ.

41. IMPACT OF COUNSELING SERVICES ON QUALITY OF LIFE OF OLDER PERSONS COMP. ADQ. LIM. INADQ.

42. COUNSELING THEORY COMP. ADQ. LIM. INADQ.

43. COUNSELING TECHNIQUES COMP. ADQ. LIM. INADQ.

44. COUNSELING CONCERNS OF OLDER PERSONS COMP. ADQ. LIM. INADQ.

45. OLDER PERSONS" UNDERSTANDINGS OF THEIR ATTITUDES ABOUT COUNSELING SERVICES COMP. ADQ. LIM. INADQ.

46. OLDER PERSONS PERCEPTIONS AND ATTITUDES ABOUT COUNSELORS COMP. ADQ. LIM. INADQ.

TO WHAT EXTENT DO YOU AGREE:

47. THAT PROFESSIONALLY TRAINED COUNSELORS ARE NEEDED TO PROVIDE ADEQUATE COUNSELING SERVICES FOR OLDER PERSONS SA A D SD

48. THAT TRAINED PARAPROFESSIONALS CAN PROVIDE ADEQUATE COUNSELING SERVICES FOR OLDER PERSONS: SA A D SD

49. THAT TRAINED VOLUNTEERS CAN PROVIDE ADEQUATE COUNSELING SERVICES FOR OLDER PERSONS: SA A D SD

50. THAT TRAINED PEER COUNSELORS (OTHER OLDER PERSONS) CAN PROVIDE ADEQUATE COUNSELING SERVICES FOR OLDER PERSONS: SA A D SD

51. THAT NO SPECIALIZED EDUCATION/TRAINING IS NEEDED TO PROVIDE ADEQUATE COUNSELING SERVICES FOR OLDER PERSONS: SA A D SD

52. THAT PERSONS FUNCTIONING AS COUNSELORS FOR OLDER PERSONS SHOULD BE PROFESSIONALLY TRAINED AND LICENSED TO INSURE PROVISION OF ADEQUATE COUNSELING SERVICES FOR OLDER PERSONS: SA A D SD

53. THAT NO SPECIALIZED TRAINING IN NEEDS AND CHARACTERISTICS OF OLDER PERSONS IS NEEDED IN ORDER TO PROVIDE ADEQUATE COUNSELING SERVICES FOR THE ELDERLY: SA A D SD

54. THAT PROFESSIONAL COUNSELORS FUNCTIONING AS DISTRICT LEVEL STAFF CONSULTANTS CAN TRAIN EXISTING DIRECT SERVICE STAFF TO ADEQUATELY PROVIDE COUNSELING SERVICES FOR OLDER PERSONS: SA A D SD

55. THAT, BY HELPING STAFF TO FOCUS ON OLDER PERSONS AS IMPORTANT HUMAN BEINGS, COUNSELING SERVICES CAN ENHANCE THE EFFECTIVENESS OF ALL OTHER SERVICES FOR OLDER PERSONS: SA A D SD

56. THAT COUNSELING SERVICES SHOULD BE PROVIDED SOLELY AS A SEPARATE AND DISTINCT SERVICE RATHER THAN AS AN INTEGRAL PART OF OTHER EXISTING SERVICE PROGRAMS FOR OLDER PERSONS: SA A D SD

57. THAT COUNSELING SERVICES SHOULD BE CARRIED OUT AS PART OF ALL OTHER HRS SERVICES FOR OLDER PERSONS: SA A D SD

58. THAT OLDER PERSONS ARE MORE EFFECTIVE COUNSELORS WITH THEIR PEERS THAN ARE YOUNGER PERSONS FUNCTIONING AS COUNSELORS FOR OLDER PERSONS: SA A D SD

59. THAT COMMUNITY MENTAL HEALTH CENTERS ARE CURRENTLY MEETING THE COUNSELING NEEDS OF OLDER PERSONS IN YOUR SERVICE AREA: SA A D SD

60. THAT HRS AGING AND ADULT SERVICES PROGRAMS ARE CURRENTLY MEETING THE COUNSELING NEEDS OF OLDER PERSONS IN YOUR SERVICE AREA: SA A D SD

61. WHAT SPECIFIC COUNSELING NEEDS DO YOU BELIEVE OLDER PERSONS HAVE WHICH ARE NOT CURRENTLY BEING MET BY EXISTING COUNSELING PROGRAMS (SUCH AS GRIEF COUNSELING, EMPLOYMENT COUNSELING, LEISURE COUNSELING, FAMILY COUNSELING OR DRUG COUNSELING)? PLEASE LIST:

APPENDIX B

STANDARDIZED PROCEDURES FOR ADMINISTRATION OF QUESTIONNAIRE

I. GENERAL:

1. The questionnaire will be administered in group settings only. No individual administrations are planned or anticipated.

2. The questionnaire will be administered either by the researcher or by a designated representative who will be given a copy of these procedures.

3. The researcher will telephone the personnel selected to administer the instrument, in those districts to which the researcher cannot travel, to discuss these procedures and to insure that they are followed, and that all questions regarding them are answered.

II. ADMINISTRATION OF QUESTIONNAIRE:

1. Participants will be welcomed and the researcher (or substitute), will introduce himself/herself and briefly explain the purpose of the study, as outlined on the cover sheet of the instrument.

2. Questionnaire will be distributed to participants by researcher or substitute.

3. Researcher (or substitute) will read aloud the instructions contained in the questionnaire, the informed consent form, and the introductory comments, and answer any questions regarding these items.

4. Researcher (or substitute) will read aloud the sample question and directions for answering the questionnaire.

5. Time will be allowed for questions at this point. Only questions that deal with the mechanics of answering the questionnaire will be answered.

6. Participants will be informed that they should use their best judgement in responding to the questions and no subject-related information will be provided during the administration.

7. Subjects will be instructed not to discuss the questionnaire among themselves while completing it.

8. All subjects will be asked to remain in the room until all participants have completed the questionnaire.

9. Researcher (or substitute) will collect all questionnaires, reviewing them to insure that all data forms, consent forms, etc. have been completed.

10. Researcher or substitute will thank participants for their cooperation and participation.

11. Researcher (or substitute) will invite participants to comment on the questionnaire and topics it raises. Pertinent comments will be recorded on a sheet separate from the questionnaire forms by the researcher or substitute.

III. MAIL ADMINISTRATION PROCEDURES

1. The District Aging and Adult Services Program Supervisor or Specialist will administer the questionnaire in those Districts which the researcher is unable to visit personally.

2. The researcher will send the random listing (by position control number) of those persons to be sampled to the Program Supervisor after discussing the standardized procedures in detail by telephone. In the same mailing, numbered copies of the questionnaire will be mailed to the program supervisor with adequate copies for all district program office staff, all AAA staff, 13 SAS workers, and 13 POS workers. The copies for each grouping will be in individually labled envelopes with a listing of the exact individuals to be sampled as determined by the random selection procedure.

3. The program supervisor will be advised to telephone the researcher with any qestuions that occur prior to or during administration of the questionnaire.

4. Following completion of the questionnaire, the completed consent forms and instruments will be collected and forwarded to the researcher in the stamped, self-addressed envelope included for that purpose.

APPENDIX C

FLORIDA AGING PROGRAM JOB DESCRIPTION SUMMARY

I. ADMINISTRATORS OF AGING PROGRAMS:

A. Aging and Adult Services State Program Office Director:

The chief officer of Aging and Adult Services Programs in Florida. Appointed by the Secretary of the Department of H.R.S. Responsible for all planning, budgeting, and programming statewide. No line authority over field staff. Serves at the pleasure of the Secretary of HRS.

B. State Program Administrators:

Program specific career service HRS employees with statewide responsibility for one or more Aging and Adult Services programs. No line authority over field staff. Work under the supervision of the State Program office director.

C. State Program Specialists:

Program and service specific career service HRS employees with statewide responsibilities for monitoring a specific Aging and Adult service program. No line authority over field staff. Work under the supervision of an Aging and Adult Service program administrator.

D. District Program Supervisor:

The chief district officer of the Aging and Adult Services program. Career service employee working under the supervision

of the H.R.S. District Administrator. Responsible for all planning, budgeting, programming and monitoring of Aging and Adult Services programs within a multi-county district.

E. District Program Specialists:

Program and service specific career service H.R.S. employees with sub-district wide responsibilities for budgeting, monitoring, and planning Aging and Adult Services programs. Work under the supervision of the district program supervisor.

F. Areawide Agency on Aging (AAA) Staff:

A grant funded agency staff with direct responsibiltiy for funding, monitoring, planning, and implementing direct service aging programs in an H.R.S. district. Work under the supervision of a public agency or private non-profit corporation and the Aging and Adult Services Program Supervisor. The AAA administers all purchase of service funding for Aging programs in the district in which it is located and is the focal point of Older Americans Act funding and aministration in its area of supervision.

G. Specialized Adult Service Casework Supervisors, Social Workers, and Social Work Assistants:

H.R.S. Career Service employees who provide direct social service to aged and adult persons who can meet the Title XX (Social Security Act) funding source means test. These services are provided for income eligible persons who are over 18 years of age, and include abuse and protective services, homemaking services, foster and boarding home placement, transportation, adult congregate living facilities and nursing

home placement among others shown in Appendix E. These staff work under the supervision of the direct service supervisor for their assigned geographic area within an H.R.S. District.

H. Purchase of Service Staff:

These staff are grant funded through a local public or private non-profit agency and provide direct services to persons over 60 years of age. They receive funding through H.R.S. and Areawide Agencies on Aging, and provide services under the supervision of the locally funded grantee agency. In most cases, services are limited to a single county geographically, and are provided without regard to financial need status. Transportation, homemaker, home repair and renovation, congregate meals, means-on-wheels, recreation, and numerous other direct service programs are provided by these staff as described in Appendix E.

APPENDIX D

FLORIDA AGING AND ADULT SERVICES
TITLE III
COUNSELING PROJECTS 1977-78

District I	Okaloosa County Counsil on Aging Project Director - Ruth R. Lovejoy P.O. Box 487 (268 Glenview Ave.) Valparaiso, FL 32580 Tel. (904) 678-6313
	Walton County Counsil on Aging Project Director - Freddy Baker #6 North 10th Street DeFuniak Springs, FL 32433 Tel. (904) 892-7331
District II	Gadsden County Senior Citizens Project Director - Danna M. Gordon 1004 Fourth Street Quincy, FL 32351 Tel. (904) 627-9758
District III	Alachua County Older American Council, Inc. Project Director - Anita M. Tassinari 1024 N.E. 14th Street Gainesville, FL 32601 Tel. (904) 375-8125
District IV	Baker County Council on Aging, Inc. Project Director - M. Annette Kjeer 42 McIver Street MacClenny, FL 32063 Tel. (904) 259-3754
	Clay County Information/Referral Services Project Director - Marilou Liddell 915 Walnut Street Green Cove Springs, FL 32043 Tel. (904) 284-9861 ext. 214

Senior Adult Neighborhood Centers
Project Director - Anne Hedgecoth
851 N. Market Street
Jacksonville, FL 32202
Tel. (904) 633-2666

Flagler County Information/Referral
Project Director - Paul Neiminen
P.O. Box 817 (701 So. Daytona Ave.)
Flagler Beach, FL 32026
Tel. (904) 439-2216

St. Johns County (C.O.A.) Information/ Referral
Project Director - Molly Bell
P.O. Box 1215
St. Augustine, FL 32084
Tel. (904) 829-6441

Volusia County (C.O.A.) Senior Activities
Project Director - John Savage
524 S. Beach Street
Daytona Beach, FL 32014
Tel. (904) 252-7362

District V

Family Counseling Center - In Home Counseling
Project Director - William J. Simpson
928 22nd Avenue South
St. Petersburg, FL 33705
Tel. (813) 822-3961

Pasco Mental Health Services
Project Director - Dr. Franklin J. Nagy
205 School Road
New Port Richey, FL 33552
Tel. (813) 847-4700

District VI

Jewish Community Center (Senior Citizens Recreation and Counseling)
Project Director - Natilee M. Brown
2808 Horatio
Tampa, FL 33609
Tel. (813) 872-4451

Manatee County (C.O.A.) Professional Counseling
Project Director - (Mr.) Marion Eyer
1105 - 6th Avenue West
Bradenton, FL 33505
Tel. (813) 747-1891

District VII	Orange County Multi-Purpose Senior Center Project Director - Alvin W. Knight 113 E Central Blvd. Orlando, FL 32801 Tel. (305) 422-4861
District VIII	Dr. Ella Piper Center, Inc. Project Director - Ray Jackson 1771 Evans Avenue Ft. Myers, FL 33901 Tel. (813) 332-5346
	Sarasota C.O.A. (Senior Outreach) Project Director - Maeve Foster 2074 Ringling Blvd., Suite 20 Sarasota, FL 33577 Tel. (813) 366-5038
District IX	Helping Hand Neighbors, Inc. Project Director - Michael L. McKinnon, Jr. 809 North 9th Street Ft. Pierce, FL 33450 Tel. (305) 464-7880
District X	Oakland Park (Social Group Center) Title XX Project Project Director - Daisy Taylor 2350 N. Andrews Avenue (mailing address: 3650 N.E. 12th) Oakland Park, FL 33334 Tel. (305) 561-6271
District XI	JESCA (James E. Scott Community Association) (Multi-Services for the Elderly) Project Director - Wanda Ross Cody 2400 N.W. 54th Street Miami, FL 33142 Tel. (305) 638-6009
	Dade Neighborhood Family II Project Director - Hilda K. Ross 1408 N.W. 10th Avenue, 6J Miami, FL 33136 Tel. (305) 325-6993

APPENDIX E

AGING AND ADULT SERVICES

Service Definitions
November, 1978

1. ABUSE ASSESSMENT. Abuse Assessment is a process whereby all complaints or reports of alleged abuse, neglect, or exploitation are investigated and the needs of the victim are determined.

2. ADULT CONGREGATE LIVING FACILITY (ACLF) LICENSURE. Adult Congregate Living Facility Licensure service is a process whereby each adult congregate living facility applies annually for a license, the facility is assessed according to licensing standards, the facility is either licensed or not licensed, technical assistance is provided to the operator/manager, and the facility is monitored on a continuing basis.

3. ADULT CONGREGATE LIVING FACILITY PLACEMENT. Adult Congregate Living Facility Placement service is a process whereby a client is determined in need of an adult congregate living facility living situation, an appropriate facility is located, the appropriate necessary arrangements are made, and the client is helped to move into the facility.

4. ADVOCACY. Advocacy service is a process by which a person attempts to affect or influence someone else's behavior on behalf of a client.

5. CHORE. Chore service is a process whereby light household tasks are completed for a client to enable him/her to remain in his/her own home.

6. CONSUMER EDUCATION. Consumer Education service consists of formal or informal instruction in managing money.

7. CONTINUING EDUCATION. Continuing Education service is formal or informal training designed to provide individuals with opportunities to acquire knowledge and skills suited to their interests and capabilities with a view toward either vocational or personal enrichment.

8. COUNSELING. Counseling service refers to a process whereby assistance is given to help resolve social and/or emotional problems through the establishment of a therapeutic relationship and application of skilled interviewing, listening, and problem solving techniques.

9. DAY CARE. Day Care service is a process whereby personal care is given in a protective setting outside of the home for less than 24 hours per day.

10. DAY CARE LICENSURE. Day Care Licensure service is a process whereby each adult day care facility applies annually for a license, the facility is assessed according to licensure standards, the facility is either licensed or denied a license, technical assistance is provided to the operator/manager, and the facility is monitored on a continuing basis.

11. DAY CARE PLACEMENT. Day Care Placement service is a process whereby a client is determined in need of a day care facility (home or center), an appropriate facility is located, appropriate necessary arrangements are made, and the client is helped to participate in the day care program.

12. DIET COUNSELING. Diet Counseling is formal or informal training in planning nutritionally sound meals provided by a registered dietitian or a person with approved training in therapeutic diets.

13. EMERGENCY MEDICAL/SOCIAL TREATMENT FACILITY PLACEMENT. Emergency Medical/Social Treatment Facility Placement service is a process whereby a client is determined in need of medical treatment or social treatment on an emergency basis, an appropriate facility or service provider is located, and appropriate arrangements are made to facilitate the provision of the service.

14. EMPLOYMENT. Employment service is a process whereby a client is provided information concerning available employment opportunities, preparatory counseling for referral to prospective employers, and is assisted in obtaining an interview with a prospective employer.

15. ESCORT. Escort service refers to the personal accompaniment of a client to a service provider, attendance during the provision of the service, and accompaniment back.

16. FAMILY DAY CARE HOME. Family Day Care Home service is a process whereby a client receives day care in a protective setting outside of his/her own home with no more than one other non-related person for a period of less than 24 hours.

17. FAMILY PLACEMENT. Family Placement service is a process whereby a client registered in the Community Care for the Elderly program is placed in a home of a caretaker approved to provide full time care, appropriate arrangements are made, and if not already in residence the client is helped to move into the family placement home.

18. FAMILY PLACEMENT HOME RECRUITMENT AND CERTIFICATION. Family Placement Home Recruitment and Certification service is a process whereby a family placement home sponsor is recruited, each family placement home and family placement sponsor is assessed on an annual basis according to certification standards, the home is either certified or not certified, technical assistance is provided, and the home is monitored on a continuing basis.

19. FOSTER CARE RECRUITMENT AND CERTIFICATION. Foster Care Recruitment and Certification service is a process whereby foster home sponsors are recruited, each foster home and foster home sponsor is assessed according to certification standards, the home is either certified or not certified, technical assistance is provided to the sponsor, and the home is monitored on a continuing basis.

20. FOSTER CARE PLACEMENT. Foster Care Placement is a process whereby a client is determined in need of an adult foster home living situation, an appropriate foster home is located, appropriate arrangements are made, and the client is helped to move into the facility.

21. FOSTER CARE SPONSORE TRAINING. Foster Care Sponsor Training service is a process whereby foster care sponsors are provided either formally or informally, training to improve their ability to provide personal care to foster care clients.

22. FRIENDLY VISITOR. Friendly Visitor service is a process whereby a client who is socially and geographically isolated is visited for the purpose of providing socialization.

23. GUARDIANSHIP. Guardianship service is a process whereby assistance is given in identifying a person, agency, or institution to be legally responsible for an incompetent adult and arrangements are made for the appropriate court-related activities.

24. HEALTH MAINTENANCE. Health Maintenance service is a process whereby receipt of routine health service is arranged for a member of a Community Care for the Elderly project or for a member of a Family Placement program.

25. HEALTH SUPPORT. Health Support service is a process whereby a client is given assistance in identifying health problems (including physical, emotional, and mental health), securing and using necessary medical treatment, prosthetic devices, special health aides and supplies.

26. HOME CARE FOR THE ELDERLY RECRUITMENT AND CERTIFICATION. Home Care for the Elderly Recruitment and Certification service is a process whereby a relative of the client is recruited to be the Home Care sponsor, and teach Home Care to the elderly persons. These sponsors are assessed annually using State certification standards. Technical Assistance is provided by the State Aging and Adult Services Program office and the home is monitored by field staff on a continuing basis.

27. HOME CARE FOR THE ELDERLY PLACEMENT. Home Care for the Elderly Placement service is a process whereby a client is determined in need of living with a relative, an appropriate home is selected, appropriate arrangements are made, and the client if not already living there is helped to move into the home.

28. HOME HEALTH AIDE. Home Health Aide service is a process whereby a person can provide one or more of the following personal care tasks for a client who cannot do it (them) himself/herself: bathing, oral hygiene, hair, back and foot care.

29. HOMEMAKER. Homemaker service is a process whereby a client in his own home receives help with any or all of the following activities: assistance with food shopping, preparation, and eating; with light housekeeping, personal laundry, and bed changing; with education of the individual regarding management in the home; with the provision of respite services so that family members who normally care for the individual can leave the home for a short while; and with special services such as handling money to pay bills and escort to other services and medical appointments.

30. HOME MANAGEMENT. Home Management service is formal or informal instruction and/or training in family functioning, maintenance and care of the home, and planning and preparation of meals.

31. HOME REPAIR. Home Repair service is a process whereby repairs to a substandard house are made to insure the safety and well-being of a client.

32. HOUSEKEEPING. Housekeeping service is a process whereby a client is provided a person on an hourly basis to do routine housekeeping in order to avoid unnecessary institutionalization of the client.

33. INFORMATION. Information service is a process whereby an adult is informed of services and opportunities available to him/her through the use of flyers, newsletters, telephone, other media, and/or through personal contact.

35. JOB TRAINING. Job Training is a process whereby a client is provided vocational training in some particular type of work or occupation before employment.

36. LEGAL. Legal service is a process whereby a client receives from an attorney or paralegal (with attorney supervision) counseling, advice, and assistance in such areas as government benefits/entitlements, consumer services, wills/estate planning, landlord/tenant, guardianship, pensions, housing, insurance, taxes, and family law.

37. LEISURE TIME ACTIVITIES. Leisure Time Activities service is a process whereby recreational activities, crafts, entertainment, hobbies, and other avocational activities are made available for a disabled or elderly client to participate in or observe.

38. MEALS, CONGREGATE. Congregate meals service is the purchasing, preparing, and provision of one meal per day to an elderly participant in a group setting.

39. MEALS, HOME DELIVERED. Home Delivered Meals or Mobile Meals service is the process of purchasing, preparing, and delivery of a nutritionally sound meal to an adult who is unable to prepare or otherwise obtain his/her own meal.

40. NURSING HOME PLACEMENT. Nursing Home Placement service is a process whereby a client is determined in need of a nursing home living situation, appropriate arrangements are made, and the client is helped to move into the facility.

41. NUTRITIONAL EDUCATION. Nutritional Education service is formal or informal instruction provided on a group basis on sound purchasing practices which will enable the client to obtain maximum nutritional benefits from expenditures for food, instruction in the preparation of nutritionally balanced meals, and assistance in the development of special diets required by health/social conditions.

42. OUTREACH. Outreach service is a process whereby hard-to-reach adults are sought out, their needs identified, and assistance is given to help them gain access to the needed services.

43. PERIODIC HEALTH SCREENING. Periodic Health Screening service is a process whereby a client is assessed to determine a need for a medical service; e.g., glaucoma screening, blood pressure screening.

44. RECREATION. Recreation service refers to activities which foster the health and social well-being of individuals through social interaction and the satisfying use of time.

45. REFERRAL. Referral service is a process whereby an adult is assisted in identifying the type of assistance needed, placement of individuals in contact with the appropriate services, and follow-up to determine whether services were received and met the need identified.

46. RESPITE CARE. Respite Care service is a process whereby care is provided in an individual's home in order to enable the caretaker(s) of a disabled or elderly adult to obtain temporary relief from their responsibility of providing care and supervision of such disabled or elderly adults.

47. SHOPPING ASSISTANCE. Shopping Assistance service is a process whereby a client is assisted in getting to and from food markets and in the selection of proper food items to improve the client's nutritional intake.

48. SPOUSE ABUSE SHELTER RECRUITMENT AND CERTIFICATION. Spouse Abuse Shelter Recruitment and Certification service is a process whereby spouse abuse shelters are recruited, each spouse abuse shelter and program is assessed on an annual basis according to certification standards, the facility is either certified or denied certification, technical assistance is provided to the operator/manager of the program, and the shelter is monitored on a continuing basis.

49. SPOUSE ABUSE SHELTER PLACEMENT. Spouse Abuse Shelter Placement service is a process whereby a client is determined as in need of a spouse abuse shelter living situation, an appropriate shelter is selected, appropriate arrangements are made, and the client is helped to move into the facility.

50. STATE HOSPITAL/RECEIVING CENTER PLACEMENT. State Hospital/ Receiving Center Placement service is a process whereby a client is determined in need of a receiving center or state hospital living situation, an appropriate facility is selected, appropriate arrangements are made, and the client is helped to move into the facility.

51. TELEPHONE REASSURANCE. Telephone Reassurance service is a process whereby designated clients are telephoned on a regularly scheduled basis to determine their safety, well-being, whether special assistance is needed, and to provide psychological reassurance.

52. TRANSPORTATION. Transportation service is the process of providing a vehicle to transport a client to and from a service provider who otherwise would not be able to receive the service.

Title XX Definitions of Services For Elderly or Disabled Adults

1. ADULT DAY CARE. Comprehensive services provided for a portion of a 24 hour day in a protective setting approved by the State agency for the purposes of personal care and to promote social, health and emotional well-being through opportunities for companionship, self-education, satisfying leisure time activities and other educational, health support or rehabilitative services. Day care for adults may include the provision of one or more meals and snacks per day.

2. CHORE SERVICES. The performance of minor home repairs, heavy cleaning, yard maintenance, errands, shopping, and other tasks which persons are unable to do for themselves and which do not require the services of a trained or supervised homemaker or other specialist.

3. COMPANIONSHIP SERVICES. The provision of basic companionship, including telephone reassurance, and the performance of certain activities, such as reading, talking, listening and writing letters, for or with individuals who are socially or geographically isolated.

4. CONSUMER EDUCATION AND PROTECTION. Formal or informal instruction in budget management, sensible purchasing habits, retirement planning and personal financial management skills necessary to avoid financial exploitation.

5. COUNSELING (Casework). Assistance in resolving social, health or emotional problems through establishment of a therapeutic client/professional relationship and application of skilled interviewing, listening, psychotherapeutic assessment and other problem solving techniques. These services are provided by, or under the supervision of, trained social workers, psychologists or members of related professions including trained group treatment leaders. Counseling may be provided on a one-to-one or a group basis. Medical and remedial care, room or board may be included when provided as an integral but subordinate part of counseling service.

6. EMPLOYMENT SERVICES. Services to enable individuals to secure appropriate paid employment, or vocational training leading to such employment, including vocational assessment, medical, social and psychological assessment, pre-vocational training, employment counseling, occupational therapy, vocational rehabilitation and job placement. Medical and remedial care, room or board may be included when provided as an integral but subordinate part of employment services.

7. ESCORT SERVICES. Personal accompaniment of individuals to and from service providers and personal assistance to enable them to obtain required health, social and rehabilitative services.

8. HEALTH EDUCATION. Training in personal nutrition, health and hygiene practices provided to assist individuals to attain and maintain a favorable condition of health.

9. HEALTH RELATED SERVICES. Assistance in securing and using necessary medical (including preventive) treatment, nursing care, occupational, physical and speech therapy and other personal care and assistance in obtaining, and training in use of, prosthetic devices and special health aids and applicances. Medical and remedial care, room or board may be included when provided as an integral but subordinate part of health support services.

10. HOME DELIVERED MEALS. The purchase, preparation and delivery of nourishing food to homes to persons who are unable to prepare or otherwise obtain their own meals.

11. HOMEMAKER SERVICES. General household management services including meal planning and preparation, child care, personal care and the supervision or performance of routine household activities by a trained homemaker or housekeeper.

12. HOUSING IMPROVEMENT SERVICES. Advice and assistance (other than financial) to individuals to aid them in obtaining needed repairs or alterations to their homes, negotiating with landlords and others for improvements of substandard housing, and obtaining improved living arrangements more suitable for their needs.

13. INFORMATION AND REFERRAL. Advice given to any family or individual, concerning community resources where service requests and needs can be met. Information and referral can be provided face-to-face, by telephone, by mail or other media; brief assessment to facilitate appropriate referral; assistance in establishing contact with the agency to which referred; advice to clients concerning effective utilization of services; arranging for transportation and escort to potential service providers, when necessary; and follow-up on referrals.

14. LEGAL SERVICES. The provision of legal advice and counseling to individuals by attorneys, and/or legal para-professionals, in civil legal matters such as consumer and employment problems, administrative matters (e.g., fair hearings on denial of public assistance or workman's compensation), housing disputes, guardianship hearings and family problems. (Note: For the purpose of Title XX, legal services will not include assistance in award generating cases.)

15. SOCIAL GROUP SERVICES. The use of group work methods and group experiences including participation in social, cultural, civic or other leisure time activities, to help individuals cope with personal problems, relieve family or social pressures, or social isolation and develop capacities for more adequate social and personal functioning.

16. TRAINING AND RELATED SERVICES. Formal or informal compensatory or remedial education and training for clients, such as literacy training, tutoring, adult basic education or other enriching learning experiences. Services may include assistance in securing education and training through the baccalaureate level, and post secondary vocational training, for which the recipient would otherwise have to pay. Medical and remedial care, room or board may be included when provided as an integral but subordinate part of education and training services.

17. TRANSPORTATION SERVICES. Travel to and from service providers or community facilities and resources.

APPENDIX F

HRS DIRECT SERVICES CLASS STUDY, SEPTEMBER 25, 1978

Present Class/Pay Grade	Proposed Class/Pay Grade (Option I)	Proposed Class/Pay Grade (Option II)
Social Work Assistant (05)	Direct Services Aide (08)	HRS Counselor Assistant (05)
Family Services Aide (10) (continuing eligibility)	Economic Services Counselor I (12)	Food Stamp Certification Specialist I (10)
Family Services Aide (10) (initial eligibility complex cases)	Economic Services Counselor II (14)	Food Stamp Certification Specialist II (12)
Social Worker (15) (on-going payments)	Economic Services Counselor III (15)	Program Counselor I-HRS (15)
Social Worker (15) (Payments, applications, OFR)	Economic Services Counselor IV (17)	Program Counselor I-HRS (15)
Family and Children's Supervisor I (18) (payments)	Economic Services Supervisor (19)	Program Counselor Supervisor-HRS (19)
Family and Children's Supervisor II (19) (OFR)	Economic Services Supervisor (19)	Program Counselor Supervisor-HRS (19)
Food Stamp Unit Supervisor (18)	Economic Services Supervisor (19)	not addressed

Present Class/Pay Grade	Proposed Class/Pay Grade (Option I)	Proposed Glass/Pay Grade (Option II)
Social Worker (15) (WIN, Specialized Family Services, AAS, Day Care)	Social and Rehabilitative Services Counselor I (15)	Program Counselor I-HRS (15)
Social Worker (15) (Protective Services, Foster Care, Adoptions)	Social and Rehabilitative Services Counselor II (17)	Program Counselor I-HRS (15)
Social Service Worker (15) (Retardation, CMS)	Social and Rehabilitative Services Counselor II (17)	not addressed
Casework (17)	Social and Rehabilitative Services Counselor II (17)	Program Counselor II-HRS (17)
VR Counselor I (15)	Social and Rehabilitative Services Counselor II (17)	Program Counselor I-HRS (15)
VR Counselor II (17)	Social and Rehabilitative Services Counselor II (17)	Program Counselor II-HRS (17)
Youth Counselor I (15)	Social and Rehabilitative Services Counselor II (17)	Program Counselor I-HRS (15)
Youth Counselor II (17)	Social and Rehabilitative Services Counselor II (17)	Program Counselor II-HRS (17)

Present Class/Pay Grade	Proposed Class/Pay Grade (Option I)	Proposed Class/Pay Grade (Option II)
Youth Counselor III (18)	Social and Rehabilitative Services Counselor II (17)	not addressed
District Intake Counselor (17)	Social and Rehabilitative Services Counselor II (17)	Program Counselor II-HRS (17)
Family and Children's Supervisor I (18) (all social services)	Social and Rehabilitative Services Supervisor (19)	Program Counselor Supervisor-HRS (19)
Family and Children's Supervisor II (19) (all social services)	Social and Rehabilitative Services Supervisor (19)	Program Counselor Supervisor-HRS (19)
VR Supervising Counselor	Social and Rehabilitative Services Supervisor (19)	Program Counselor Supervisor-HRS (19)
Field Services Counselor Supervisor (19)	Social and Rehabilitative Services Supervisor (19)	Program Counselor Supervisor-HRS (19)
District Intake Supervisor (19)	Social and Rehabilitative Services Supervisor (19)	Program Counselor Supervisor-HRS (19)

APPENDIX G

CROSSTABULATION OF SAMPLE CHARACTERISTICS:
SUBJECT IN WHICH HIGHEST DEGREE WAS
EARNED BY SEX AND RACE

Subject		Race			
N % Total	Caucasian		Ethnic Minority		
	Sex		Sex		
	Male	Female	Male	Female
Administration	19 5.9	9 2.8	1 2.0	2 4.0
Counseling	9 2.8	6 1.9	1 2.0	1 2.0
Social Work	18 5.6	62 19.2	0 0.0	13 26.0
Gerontology	3 .9	6 1.9	0 0.0	0 0.0
Psychology	9 2.8	16 5.0	1 2.0	0 0.0
Sociology	9 2.8	20 6.2	0 0.0	3 6.0
Other	27 8.4	109 33.7	5 10.0	23 46.0
Total	94 25.3	228 61.3	8 2.1	42 11.3

APPENDIX H

CROSSTABULATION OF SAMPLE CHARACTERISTICS:
EDUCATION BY SEX AND RACE

Education	Race			
N % Total	Caucasian		Ethnic Minority	
	Sex		Sex	
	Male	Female	Male	Female
Grades 0-11	0 0.0	3 .8	0 0.0	0 0.0
High School	5 1.3	29 7.8	3 .8	14 3.8
A.A. Degree	5 1.3	12 3.2	1 .3	1 .3
4 Year Degree	50 13.4	125 33.6	4 1.1	19 5.1
Masters Degree	29 7.8	54 14.5	0 0.0	8 2.2
Ed.S. Degree	1 .3	3 .8	0 0.0	0 0.0
Ph.D.	1 .3	1 .3	0 0.0	0 0.0
Other	4 1.1	0 0.0	0 0.0	0 0.0
Total	95 25.5	227 61.0	8 2.2	42 11.3

APPENDIX I

CROSSTABULATION OF SAMPLE CHARACTERISTICS:
WORK LOCATION BY SEX AND RACE

Location	Race			
N % Total	Caucasian		Ethnic Minority	
	Sex		Sex	
	Male	Female	Male	Female
District I	8 2.2	18 4.8	0 0.0	1 .3
District II	7 1.9	17 4.6	1 .3	3 .8
District III	8 2.2	21 5.7	0 0.0	4 1.1
District IV	3 .8	22 5.9	0 0.0	7 1.9
District V	1 .3	25 6.7	1 .3	5 1.3
District VI	10 2.6	18 4.8	3 .8	3 .8
District VII	10 2.6	15 4.0	1 .3	4 1.1

Location N % Total	Race			
	Caucasian		Ethnic Minority	
	Sex		Sex	
	Male	Female	Male	Female
District VIII	11 3.0	20 5.4	0 0.0	0 0.0
District IX	9 2.4	19 5.1	0 0.0	4 1.1
District X	8 2.2	18 4.8	1 .3	2 .5
District XI	5 1.3	17 4.6	1 .3	7 1.9
State Program Office	15 4.0	17 4.6	0 0.0	2 .5
Total	95 25.5	227 61.0	8 2.2	42 11.3

APPENDIX J

CROSSTABULATION OF SAMPLE CHARACTERISTICS: EDUCATION BY SUBJECT

Education	Subject						
N % Total	Adminis-tration	Counseling	Social Work	Gerontology	Psychology	Sociology	Other
Grades 0 - 11	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0	3 0.8
High School	1 0.3	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0	49 13.1
A.A. Degree	3 0.8	0 0.0	3 0.8	0 0.0	0 0.0	0 0.0	13 3.5
4 Year Degree	18 4.8	4 1.1	55 14.7	1 0.3	23 6.2	27 7.2	71 19.0
Masters Degree	5 1.3	11 2.9	36 9.7	8 2.1	2 0.5	5 1.3	25 6.7
Ed.S. Degree	2 0.5	2 0.5	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0
Ph.D.	1 0.3	1 0.3	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0
Other	1 0.3	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0	3 0.8
Total	31 8.3	18 4.8	94 25.2	9 2.4	25 6.7	32 8.6	164 44.0

APPENDIX K

CROSSTABULATION OF SAMPLE CHARACTERISTICS:
AGE BY SEX AND RACE

Age N % Total	Race			
	Caucasian		Ethnic Minority	
	Sex		Sex	
	Male	Female	Male	Female
Under 25	3 .8	12 3.2	0 0.0	2 .5
25-35	37 10.0	95 25.5	1 .3	24 6.5
36-45	20 5.4	32 8.6	5 1.3	5 1.3
46-55	16 4.3	55 14.8	2 .5	6 1.6
56-60	8 2.2	21 5.7	0 0.0	3 .8
61-70	10 2.6	10 2.6	0 0.0	1 .3
71-80	1 .3	2 .5	0 0.0	1 .3
Over 81	0 0.0	0 0.0	0 0.0	0 0.0
Total	95 25.5	227 61.0	8 2.2	42 11.3

APPENDIX L

CROSSTABULATION OF SAMPLE CHARACTERISTICS: WORK LOCATION BY AGE AND SEX

Location	Age													
N % Total	Under 25		25-35		36-45		46-55		56-60		61-70		71-80	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
District I	0	0	6	6	1	5	1	7	0	0	0	0	0	1
	0.0	0.0	1.6	1.6	0.3	1.3	0.3	1.9	0.0	0.0	0.0	0.0	0.0	0.3
District II	0	0	3	8	5	2	0	7	0	2	0	0	0	1
	0.0	0.0	0.8	2.2	1.3	0.5	0.0	1.9	0.0	0.5	0.0	0.0	0.0	0.3
District III	0	2	4	11	1	1	2	7	1	2	0	2	0	0
	0.0	0.5	1.1	3.0	0.3	0.3	0.5	1.9	0.3	0.5	0.0	0.5	0.0	0.0
District IV	0	1	1	14	1	3	0	6	0	4	1	1	0	0
	0.0	0.3	0.3	3.8	0.3	0.8	0.0	1.6	0.0	1.1	0.3	0.3	0.0	0.0
District V	0	3	1	12	0	2	0	7	0	3	1	2	0	1
	0.0	0.8	0.3	3.2	0.0	0.5	0.0	1.9	0.0	0.8	0.3	0.5	0.0	0.3
District VI	2	2	3	13	3	2	3	4	1	0	1	0	0	0
	0.5	0.5	0.8	3.5	0.8	0.5	0.8	1.1	0.3	0.0	0.3	0.0	0.0	0.0
District VII	0	0	2	6	4	4	2	7	2	2	1	0	0	0
	0.0	0.0	0.5	1.6	1.1	1.1	0.5	1.9	0.5	0.5	0.3	0.0	0.0	0.0
District VIII	0	0	5	11	1	2	2	4	2	2	1	1	0	0
	0.0	0.0	1.3	3.0	0.3	0.5	0.5	1.1	0.5	0.5	0.3	0.3	0.0	0.0
District IX	0	3	3	6	1	4	2	6	0	2	3	2	0	0
	0.0	0.8	0.8	1.6	0.3	1.1	0.5	1.6	0.0	0.5	0.8	0.5	0.0	0.0
District X	1	0	5	10	1	6	1	1	1	2	0	1	0	0
	0.3	0.0	1.3	2.7	0.3	1.6	0.3	0.3	0.3	0.5	0.0	0.3	0.0	0.0
District XI	0	3	1	11	4	4	1	2	0	3	0	1	0	0
	0.0	0.8	0.3	3.0	1.1	1.1	0.3	0.5	0.0	0.8	0.0	0.3	0.0	0.0
State Office	0	0	4	11	3	2	4	3	1	2	2	1	1	0
	0.0	0.0	1.1	3.0	0.8	0.5	1.1	0.8	0.3	0.5	0.5	0.3	0.3	0.0
Total	3	14	38	119	25	37	18	61	8	24	10	11	1	3
	0.8	3.8	10.2	32.0	6.7	10.0	4.8	16.4	2.2	6.5	2.7	3.0	0.3	0.8

APPENDIX M

CROSSTABULATION OF SAMPLE CHARACTERISTICS: POSITION BY AGE AND SEX

Age N % Total	Position									
	State Office		District Program Staff		AAA Staff		Project Staff		SAS Staff	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Under 25	0 0.0	0 0.0	0 0.0	1 0.3	2 0.5	5 1.3	0 0.0	5 1.3	1 0.3	3 0.8
25 - 35	4 1.1	11 3.0	0 0.0	10 2.7	3 0.8	20 5.4	14 3.8	23 6.7	17 4.6	55 14.8
36 - 45	3 0.8	2 0.5	7 1.8	7 1.8	3 0.8	3 0.8	6 1.6	16 4.3	6 1.6	9 2.4
46 - 55	4 1.1	3 0.8	1 0.3	1 0.3	0 0.0	3 0.8	7 1.8	33 8.9	6 1.6	21 5.7
56 - 60	1 0.3	2 0.5	2 0.5	5 1.3	2 0.5	3 0.8	3 0.8	6 1.6	0 0.0	8 2.2
61 - 70	2 0.5	1 0.3	2 0.5	0 0.0	0 0.0	1 0.3	3 0.8	5 1.3	3 0.8	4 1.1
71 - 80	1 0.3	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0	2 0.5	0 0.0	1 0.3
Total	15 4.0	19 5.1	12 3.2	24 6.5	10 2.5	35 9.4	33 8.9	90 24.2	33 8.9	101 27.2

APPENDIX N

ITEM MEANS (AND STANDARD DEVIATIONS) FOR MALES AND FEMALES

Item Number	Male	Female	Item Number	Male	Female
1	1.60 (.60)	1.64 (.59)	16	2.99 (.95)	3.21 (.93)
2	2.47 (.74)	2.31 (.73)	17	3.34 (.80)	3.27 (.81)
3	2.18 (.84)	2.12 (.79)	18	1.84 (1.03)	1.70 (.82)
4	2.47 (.87)	2.74 (.73)	19	1.84 (.79)	1.80 (.85)
5	2.64 (.83)	2.58 (.79)	20	2.95 (.92)	2.99 (.90)
6	2.12 (.78)	2.03 (.73)	21	3.49 (.74)	3.48 (.74)
7	1.50 (.65)	1.52 (.59)	22	2.12 (1.16)	2.04 (1.10)
8	1.69 (.71)	1.69 (.72)	23	2.44 (.98)	2.12 (.96)
9	1.47 (.64)	1.55 (.62)	24	2.26 (1.09)	2.49 (1.05)
10	1.68 (.72)	1.62 (.66)	25	3.23 (.96)	3.30 (.91)
11	2.07 (.82)	2.04 (.73)	26	2.93 (.68)	2.86 (.71)
12	2.08 (.72)	2.11 (.74)	27	2.62 (.86)	2.72 (.94)
13	1.94 (.89)	1.96 (.84)	28	2.36 (.70)	2.42 (.74)
14	1.77 (.88)	1.61 (.67)	29	2.71 (.85)	2.79 (.83)
15	1.74 (.79)	1.71 (.77)	30	2.28 (.72)	2.25 (.69)

Item Number	Male	Female	Item Number	Male	Female
31	2.29	2.25	46	2.54	2.47
	(.76)	(.70)		(.89)	(.81)
32	2.43	2.41	47	1.61	1.84
	(.75)	(.69)		(.77)	(.79)
33	2.69	2.67	48	2.05	2.07
	(.75)	(.69)		(.71)	(.64)
34	2.68	2.63	49	2.60	2.61
	(.89)	(.85)		(.87)	(.75)
35	2.53	2.52	50	2.31	2.31
	(.93)	(.92)		(.74)	(.72)
36	1.69	1.73	51	3.47	3.44
	(.70)	(.79)		(.70)	(.66)
37	2.09	2.12	52	2.65	2.67
	(.81)	(.84)		(.88)	(.84)
38	1.76	1.75	53	3.43	3.48
	(.63)	(.74)		(.62)	(.60)
39	2.00	1.91	54	2.49	2.26
	(.70)	(.83)		(.67)	(.66)
40	1.67	1.84	55	1.64	1.63
	(.72)	(.85)		(.54)	(.58)
41	2.38	2.32	56	2.88	2.99
	(.84)	(.82)		(.91)	(.82)
42	2.30	2.44	57	1.84	1.77
	(.94)	(.86)		(.64)	(.65)
43	2.17	2.39	58	2.68	2.73
	(.90)	(.88)		(.70)	(.68)
44	2.20	2.30	59	3.24	3.27
	(.84)	(.84)		(.63)	(.64)
45	2.53	2.48	60	3.03	2.97
	(.84)	(.82)		(.60)	(.67)

APPENDIX O

ITEM MEANS (AND STANDARD DEVIATIONS) FOR EDUCATION

Item Number	0 - 11	High School	A.A. Degree	4 Year Degree	Masters Degree	Ed.S. Degree	Ph.D. Degree	Other
1	1.67	1.67	1.74	1.61	1.63	2.00	1.50	1.25
	(.58)	(.55)	(.65)	(.56)	(.63)	(1.41)	(.71)	(.50)
2	1.67	2.15	2.06	2.30	2.61	3.50	2.50	2.67
	(.58)	(.68)	(.56)	(.70)	(.76)	(.58)	(.71)	(1.15)
3	1.67	2.06	1.94	2.13	2.22	2.25	2.00	2.75
	(.58)	(.84)	(.54)	(.81)	(.76)	(1.26)	(0.00)	(1.26)
4	2.00	2.29	2.05	2.50	2.60	2.00	2.50	3.00
	(1.00)	(.83)	(.41)	(.79)	(.68)	(.82)	(.71)	(1.41)
5	2.00	2.42	2.32	2.64	2.71	2.00	2.50	2.75
	(1.00)	(.86)	(.67)	(.84)	(.66)	(.82)	(.71)	(1.26)
6	2.00	2.08	2.11	1.95	2.22	2.00	2.50	2.75
	(1.00)	(.77)	(.88)	(.72)	(.70)	(.82)	(.71)	(1.26)
7	1.33	1.73	1.63	1.45	1.53	2.00	1.00	1.25
	(.58)	(.60)	(.60)	(.57)	(.64)	(1.41)	(0.00)	(.50)
8	2.00	1.92	1.84	1.67	1.57	2.00	1.00	1.50
	(1.00)	(.80)	(.83)	(.67)	(.69)	(1.41)	(0.00)	(.58)
9	1.67	1.82	1.84	1.41	1.54	1.25	1.50	2.00
	(.58)	(.65)	(.83)	(.56)	(.60)	(.50)	(.71)	(1.41)
10	2.00	1.90	1.79	1.50	1.69	1.50	2.50	2.25
	(0.00)	(.68)	(.54)	(.64)	(.69)	(.58)	(.71)	(.96)
11	2.00	2.06	2.11	2.00	2.13	1.75	2.50	2.25
	(0.00)	(.73)	(.57)	(.76)	(.79)	(.50)	(.71)	(1.50)
12	2.00	2.14	2.05	2.03	2.25	1.75	2.50	2.50
	(1.00)	(.67)	(.62)	(.73)	(.78)	(.50)	(.71)	(1.29)
13	1.67	1.86	2.05	1.83	2.23	1.75	2.50	2.75
	(.58)	(.70)	(.97)	(.85)	(.84)	(.96)	(.71)	(1.50)
14	1.67	1.47	1.95	1.65	1.70	1.50	1.50	2.00
	(.58)	(.61)	(.91)	(.75)	(.69)	(.58)	(.71)	(1.41)
15	1.67	1.88	1.95	1.69	1.64	1.75	1.50	1.75
	(1.15)	(.89)	(.97)	(.73)	(.75)	(.96)	(.71)	(.50)

Item Number	0 - 11	High School	A.A. Degree	4 Year Degree	Masters Degree	Ed.S. Degree	Ph.D. Degree	Other
16	4.00	3.25	2.58	3.19	3.13	2.75	3.00	2.75
	(0.00)	(.98)	(1.30)	(.90)	(.90)	(.50)	(0.00)	(1.26)
17	1.67	2.86	3.11	3.32	3.49	4.00	4.00	3.50
	(1.15)	(1.06)	(.88)	(.75)	(.64)	(0.00)	(0.00)	(.58)
18	2.00	1.57	2.16	1.69	1.88	1.25	2.00	1.25
	(1.73)	(.83)	(1.12)	(.86)	(.89)	(.50)	(0.00)	(.50)
19	1.67	1.90	2.00	1.87	1.62	2.00	1.00	1.75
	(.58)	(.90)	(1.05)	(.85)	(.73)	(.82)	(0.00)	(.50)
20	3.00	3.16	2.58	2.96	3.00	3.25	3.00	3.00
	(1.73)	(.90)	(1.02)	(.90)	(.89)	(.96)	(0.00)	(0.00)
21	2.33	3.33	3.05	3.51	3.59	3.50	4.00	4.00
	(1.15)	(.84)	(.91)	(.72)	(.61)	(.58)	(0.00)	(0.00)
22	1.00	1.69	2.74	2.05	2.25	1.50	2.00	1.50
	(0.00)	(.99)	(1.24)	(1.10)	(1.14)	(.58)	(0.00)	(1.00)
23	2.00	2.14	1.95	2.20	2.31	3.00	2.00	2.00
	(1.00)	(.98)	(.97)	(.95)	(1.03)	(.82)	(1.41)	(.82)
24	3.33	2.80	2.21	2.39	2.27	3.00	2.00	2.75
	(1.15)	(1.04)	(1.08)	(1.04)	(1.09)	(1.41)	(1.41)	(.96)
25	2.67	3.31	2.84	3.37	3.18	2.50	4.00	3.75
	(1.53)	(.86)	(1.01)	(.87)	(.98)	(1.29)	(0.00)	(.50)
26	2.67	2.63	3.11	2.82	3.04	3.75	3.00	3.00
	(.58)	(.75)	(.66)	(.69)	(.65)	(.50)	(0.00)	(.82)
27	3.00	2.28	2.63	2.77	2.79	2.75	2.00	2.00
	(1.00)	(.88)	(.76)	(.94)	(.85)	(1.50)	(0.00)	(.82)
28	2.33	2.53	2.37	2.36	2.43	3.00	2.50	2.50
	(.58)	(.77)	(.76)	(.73)	(.70)	(.82)	(.71)	(1.00)
29	2.33	2.68	2.68	2.75	2.84	3.75	2.50	2.75
	(.58)	(.89)	(.75)	(.81)	(.89)	(.50)	(.71)	(.96)
30	2.00	2.14	2.58	2.23	2.31	2.25	2.50	2.50
	(0.00)	(.66)	(.77)	(.69)	(.73)	(.50)	(.71)	(1.00)

Item Number	0 - 11	High School	A.A. Degree	4 Year Degree	Masters Degree	Ed.S. Degree	Ph.D. Degree	Other
31	2.00	2.14	2.42	2.28	2.26	2.50	2.50	2.50
	(0.00)	(.69)	(.69)	(.73)	(.73)	(.58)	(.71)	(1.00)
32	2.33	2.39	2.32	2.41	2.44	2.50	2.50	2.50
	(.58)	(.75)	(.58)	(.71)	(.69)	(.58)	(.71)	(1.29)
33	2.33	2.41	2.58	2.73	2.70	2.75	2.50	3.25
	(.58)	(.75)	(.69)	(.70)	(.68)	(.96)	(.71)	(.50)
34	3.00	2.55	2.79	2.61	2.71	2.50	3.00	3.50
	(1.00)	(.86)	(1.03)	(.83)	(.88)	(1.29)	(0.00)	(.58)
35	2.33	2.38	2.32	2.53	2.68	1.00	3.00	3.00
	(1.15)	(.89)	(.89)	(.92)	(.91)	(0.00)	(0.00)	(.82)
36	1.67	2.29	1.74	1.65	1.59	1.00	1.00	2.00
	(.58)	(.88)	(.93)	(.71)	(.68)	(0.00)	(0.00)	(0.00)
37	2.00	2.60	2.21	2.07	1.99	1.00	1.50	1.75
	(1.00)	(.78)	(.86)	(.80)	(.82)	(0.00)	(.71)	(.50)
38	2.00	2.12	1.74	1.76	1.57	1.00	1.00	1.75
	(1.00)	(.68)	(.65)	(.68)	(.75)	(0.00)	(0.00)	(.50)
39	2.67	2.29	1.89	1.95	1.72	1.00	1.50	2.00
	(.58)	(.78)	(.74)	(.75)	(.83)	(0.00)	(.71)	(.82)
40	2.67	2.39	1.58	1.73	1.70	1.00	1.00	1.00
	(.58)	(.90)	(.77)	(.78)	(.72)	(0.00)	(0.00)	(0.00)
41	2.33	2.73	2.16	2.27	2.37	1.75	2.00	2.00
	(.58)	(.73)	(.76)	(.82)	(.85)	(.96)	(0.00)	(.82)
42	2.67	2.75	2.68	2.46	2.08	1.50	1.50	2.00
	(.58)	(.74)	(.82)	(.83)	(.97)	(1.00)	(.71)	(.82)
43	3.00	2.88	2.42	2.35	2.01	1.50	1.50	2.00
	(1.00)	(.77)	(.77)	(.83)	(.96)	(1.00)	(.71)	(.82)
44	2.33	2.70	2.53	2.23	2.12	1.50	1.50	2.00
	(.58)	(.74)	(.84)	(.77)	(.98)	(1.00)	(.71)	(.82)
45	3.00	2.84	2.68	2.46	2.34	2.00	2.00	2.75
	(1.00)	(.68)	(.67)	(.80)	(.91)	(.82)	(0.00)	(1.26)

Item Number	0 - 11	High School	A.A. Degree	4 Year Degree	Masters Degree	Ed.S. Degree	Ph.D. Degree	Other
46	2.67	2.71	2.58	2.47	2.41	2.00	2.00	2.75
	(.58)	(.76)	(.69)	(.82)	(.91)	(.82)	(0.00)	(1.26)
47	2.00	2.06	2.00	1.79	1.57	1.00	1.00	1.75
	(0.00)	(.86)	(.94)	(.77)	(.72)	(0.00)	(0.00)	(.96)
48	2.33	1.94	2.00	2.06	2.14	2.75	1.50	1.75
	(.58)	(.68)	(.58)	(.65)	(.64)	(.96)	(.71)	(.96)
49	2.33	2.35	2.58	2.69	2.62	3.00	2.50	2.00
	(.58)	(.74)	(.77)	(.81)	(.71)	(.82)	(.71)	(.82)
50	2.67	2.31	2.74	2.31	2.24	2.75	2.00	1.75
	(.58)	(.76)	(.65)	(.72)	(.72)	(.96)	(0.00)	(.50)
51	3.33	3.10	3.21	3.49	3.60	3.75	2.50	3.25
	(.58)	(.78)	(.86)	(.63)	(.56)	(.50)	(.71)	(.96)
52	2.33	2.76	2.89	2.72	2.48	1.50	2.50	2.75
	(.58)	(.74)	(.88)	(.82)	(.94)	(1.00)	(.71)	(.50)
53	2.33	2.24	2.32	3.46	3.66	4.00	3.50	3.50
	(1.15)	(.62)	(.48)	(.62)	(.48)	(0.00)	(.71)	(.58)
54	2.00	2.29	2.42	2.27	2.42	2.25	3.00	2.50
	(0.00)	(.67)	(.69)	(.67)	(.67)	(.96)	(0.00)	(.58)
55	2.00	1.80	1.79	1.65	1.49	1.25	1.00	1.25
	(0.00)	(.63)	(.54)	(.56)	(.52)	(.50)	(0.00)	(.50)
56	2.67	2.66	2.84	2.98	3.10	3.25	3.00	3.00
	(.58)	(.82)	(.83)	(.83)	(.84)	(.96)	(0.00)	(1.41)
57	2.33	2.00	1.95	1.77	1.70	1.25	1.50	1.25
	(.58)	(.66)	(.71)	(.64)	(.62)	(.50)	(.71)	(.50)
58	2.33	2.53	2.79	2.78	2.71	3.00	2.00	2.25
	(.58)	(.64)	(.63)	(.68)	(.72)	(.82)	(0.00)	(.96)
59	2.00	2.98	3.11	3.31	3.37	4.00	3.00	3.25
	(0.00)	(.71)	(.57)	(.64)	(.53)	(0.00)	(0.00)	(.96)
60	2.00	2.72	2.95	2.94	3.21	3.75	3.50	3.00
	(0.00)	(.73)	(.52)	(.62)	(.61)	(.50)	(.71)	(.82)

APPENDIX P

ITEM MEANS (AND STANDARD DEVIATIONS)
FOR AGE

Item Number	Under 25	25-35	36-45	46-55	56-60	61-70	71-80
1	1.59	1.67	1.63	1.56	1.72	1.50	1.75
	(.62)	(.59)	(.58)	(.57)	(.68)	(.51)	(.50)
2	2.71	2.37	2.44	2.24	2.26	2.36	2.00
	(.77)	(.69)	(.79)	(.71)	(.77)	(.85)	(.00)
3	1.70	2.20	2.08	2.11	2.16	2.14	2.50
	(.85)	(.75)	(.85)	(.85)	(.81)	(.77)	(.58)
4	2.18	2.52	2.44	2.48	2.41	2.50	2.50
	(.73)	(.75)	(.84)	(.83)	(.67)	(.74)	(1.00)
5	2.47	2.71	2.45	2.60	2.50	2.50	2.25
	(.62)	(.78)	(.86)	(.86)	(.72)	(.80)	(.50)
6	1.82	2.15	1.98	2.01	2.00	2.00	2.00
	(.81)	(.78)	(.76)	(.71)	(.67)	(.62)	(.82)
7	1.18	1.51	1.55	1.42	1.81	1.64	1.50
	(.53)	(.53)	(.76)	(.50)	(.82)	(.58)	(.58)
8	1.35	1.70	1.68	1.70	1.81	1.73	1.50
	(.61)	(.75)	(.72)	(.72)	(.78)	(.46)	(.58)
9	1.41	1.52	1.48	1.58	1.44	1.64	1.75
	(.62)	(.61)	(.57)	(.74)	(.50)	(.73)	(.50)
10	1.41	1.65	1.60	1.67	1.66	1.59	1.75
	(.71)	(.71)	(.66)	(.70)	(.55)	(.59)	(.50)
11	1.76	2.02	2.07	2.09	2.22	2.05	1.75
	(.66)	(.75)	(.76)	(.77)	(.66)	(.95)	(.50)
12	1.82	2.13	2.13	2.09	2.09	2.09	2.25
	(.73)	(.74)	(.78)	(.76)	(.59)	(.81)	(.50)

Item Number	Under 25	25-35	36-45	46-55	56-60	61-70	71-80
13	1.65	1.99	1.97	2.00	1.97	1.73	1.75
	(1.00)	(.84)	(.87)	(.91)	(.78)	(.83)	(.50)
14	1.76	1.72	1.71	1.62	1.38	1.59	1.25
	(.90)	(.77)	(.73)	(.61)	(.55)	(.91)	(.50)
15	1.82	1.64	1.82	1.71	1.75	1.82	1.75
	(.88)	(.70)	(.88)	(.85)	(.72)	(.66)	(.96)
16	3.06	3.10	3.03	3.29	3.19	3.23	3.75
	(.97)	(.96)	(1.00)	(.88)	(.86)	(.92)	(.50)
17	3.35	3.29	3.42	3.14	3.38	3.36	2.50
	(.79)	(.83)	(.69)	(.89)	(.75)	(.66)	(1.29)
18	1.35	1.62	1.68	1.86	2.06	2.23	1.25
	(.49)	(.81)	(.78)	(.96)	(1.01)	(1.15)	(.50)
19	2.53	1.80	1.84	1.81	1.56	1.59	2.00
	(.94)	(.77)	(.83)	(.92)	(.84)	(.67)	(.82)
20	2.89	2.99	2.97	2.96	3.03	2.95	3.50
	(1.11)	(.85)	(1.02)	(.88)	(.82)	(1.09)	(.58)
21	3.24	3.57	3.35	3.41	3.50	3.14	3.25
	(.90)	(.70)	(.56)	(.79)	(.72)	(.99)	(.96)
22	2.59	1.97	1.94	2.10	2.31	2.32	1.50
	(1.18)	(1.06)	(1.08)	(1.14)	(1.18)	(1.32)	(.58)
23	2.65	2.20	2.37	2.16	2.06	2.00	1.50
	(.93)	(.94)	(.98)	(1.04)	(1.08)	(.76)	(.58)
24	1.94	2.39	2.40	2.49	2.56	2.45	3.50
	(1.03)	(1.08)	(1.05)	(1.08)	(1.05)	(1.01)	(.58)
25	2.82	3.34	3.29	3.22	3.34	3.32	3.50
	(1.24)	(.89)	(.93)	(.87)	(1.00)	(.99)	(.58)
26	3.12	2.86	2.94	2.85	2.88	2.73	3.00
	(.70)	(.65)	(.70)	(.65)	(.91)	(.83)	(.82)
27	2.47	2.71	2.59	2.79	2.78	2.59	2.00
	(1.12)	(.92)	(.94)	(.84)	(.98)	(.85)	(.82)
28	2.65	2.39	2.39	2.35	2.53	2.32	3.00
	(.49)	(.72)	(.82)	(.70)	(.67)	(.84)	(.82)
29	2.71	2.85	2.77	2.66	2.88	2.55	2.00
	(.85)	(.85)	(.73)	(.85)	(.71)	(1.06)	(.82)
30	2.41	2.21	2.40	2.16	2.50	2.14	1.75
	(.71)	(.66)	(.73)	(.69)	(.76)	(.71)	(.50)
31	2.71	2.18	2.42	2.24	2.38	2.09	1.75
	(.69)	(.64)	(.71)	(.77)	(.83)	(.81)	(.50)
32	2.59	2.35	2.48	2.47	2.44	2.32	2.25
	(.51)	(.68)	(.72)	(.77)	(.72)	(.72)	(.96)
33	2.76	2.72	2.68	2.59	2.63	2.62	2.25
	(.66)	(.64)	(.70)	(.78)	(.75)	(.86)	(1.26)
34	2.65	2.68	2.53	2.60	2.56	2.82	3.75
	(.86)	(.76)	(1.04)	(.89)	(.88)	(.85)	(.50)
35	2.35	2.65	2.65	2.38	2.75	2.41	2.00
	(1.06)	(.86)	(.96)	(.91)	(.92)	(1.01)	(1.15)
36	1.94	1.69	1.79	1.66	1.78	1.55	2.50
	(.83)	(.69)	(.85)	(.85)	(.97)	(.67)	(.58)

Item Number	Under 25	25-35	36-45	46-55	56-60	61-70	71-80
37	2.35	2.13	2.05	2.05	2.13	2.09	2.50
	(.93)	(.75)	(.93)	(.91)	(.75)	(.75)	(1.29)
38	1.76	1.79	1.71	1.71	1.84	1.59	1.75
	(.90)	(.70)	(.73)	(.68)	(.77)	(.73)	(.50)
39	1.76	2.00	1.87	1.89	1.94	1.86	2.25
	(.97)	(.79)	(.76)	(.77)	(.76)	(.89)	(1.26)
40	1.82	1.81	1.68	1.80	1.94	1.64	2.75
	(.95)	(.75)	(.86)	(.81)	(.84)	(.79)	(1.50)
41	2.47	2.39	2.28	2.29	2.42	2.05	2.75
	(.94)	(.79)	(.80)	(.88)	(.76)	(.90)	(.96)
42	2.35	2.49	2.26	2.25	2.47	2.64	2.25
	(.93)	(.87)	(.89)	(.90)	(.76)	(1.00)	(.50)
43	2.53	2.36	2.10	2.32	2.38	2.59	2.75
	(.94)	(.84)	(.88)	(.98)	(.83)	(1.01)	(.50)
44	2.35	2.31	2.21	2.18	2.38	2.18	2.50
	(.79)	(.83)	(.86)	(.86)	(.83)	(1.01)	(.58)
45	2.53	2.52	2.46	2.42	2.59	2.41	3.25
	(.94)	(.76)	(.92)	(.79)	(.80)	(1.10)	(.50)
46	2.59	2.48	2.47	2.44	2.59	2.41	3.25
	(.94)	(.76)	(.86)	(.90)	(.80)	(1.01)	(.50)
47	1.65	1.79	1.74	1.82	2.06	1.31	1.50
	(.70)	(.78)	(.75)	(.83)	(.98)	(.48)	(.58)
48	2.12	2.02	2.10	2.01	2.22	2.09	2.50
	(.78)	(.61)	(.77)	(.63)	(.61)	(.68)	(.58)
49	2.41	2.55	2.74	2.67	2.59	2.73	2.25
	(.94)	(.78)	(.85)	(.69)	(.80)	(.70)	(.96)
50	2.06	2.16	2.35	2.43	2.63	2.59	2.50
	(.75)	(.65)	(.79)	(.69)	(.87)	(.67)	(1.00)
51	3.47	3.55	3.44	3.29	3.22	3.59	3.25
	(.62)	(.57)	(.69)	(.74)	(.87)	(.59)	(.96)
52	2.29	2.67	2.68	2.78	2.75	2.36	2.25
	(.77)	(.81)	(.92)	(.77)	(.98)	(1.00)	(.50)
53	3.41	3.54	3.47	3.37	3.28	3.64	3.50
	(.87)	(.55)	(.59)	(.63)	(.63)	(.58)	(.58)
54	2.18	2.32	2.48	2.26	2.50	2.32	2.50
	(.73)	(.68)	(.81)	(.59)	(.62)	(.48)	(.58)
55	1.59	1.65	1.62	1.66	1.53	1.55	2.00
	(.62)	(.56)	(.55)	(.57)	(.51)	(.60)	(.82)
56	3.00	3.00	2.81	3.01	2.97	2.77	3.50
	(.71)	(.84)	(.94)	(.76)	(.90)	(.92)	(.58)
57	1.59	1.80	1.84	1.77	1.63	1.95	2.25
	(.51)	(.63)	(.71)	(.64)	(.55)	(.72)	(1.26)
58	2.76	2.88	2.79	2.62	2.44	2.23	2.00
	(.56)	(.61)	(.66)	(.70)	(.76)	(.81)	(.00)
59	3.18	3.34	3.32	3.19	3.13	3.23	2.50
	(.64)	(.61)	(.54)	(.70)	(.75)	(.69)	(.58)
60	3.12	2.99	3.05	2.94	2.98	2.95	2.50
	(.78)	(.61)	(.69)	(.73)	(.54)	(.65)	(.58)

APPENDIX Q

ITEM MEANS (AND STANDARD DEVIATIONS) FOR RACE

Item Number	Caucasian	Ethnic Minority	Item Number	Caucasian	Ethnic Minority
1	1.63	1.60	16	3.13	3.30
	(.59)	(.57)		(.93)	(.99)
2	2.40	2.02	17	3.37	2.74
	(.73)	(.69)		(.74)	(1.05)
3	2.16	2.00	18	1.79	1.46
	(.80)	(.83)		(.91)	(.68)
4	2.50	2.26	19	1.81	1.84
	(.76)	(.85)		(.84)	(.84)
5	2.64	2.32	20	2.95	3.16
	(.77)	(.96)		(.92)	(.79)
6	2.09	1.82	21	3.49	3.42
	(.74)	(.75)		(.74)	(.76)
7	1.51	1.56	22	2.09	1.86
	(.60)	(.64)		(1.12)	(1.05)
8	1.70	1.66	23	2.21	2.20
	(.71)	(.77)		(.98)	(.95)
9	1.53	1.50	24	2.44	2.32
	(.63)	(.61)		(1.07)	(1.06)
10	1.63	1.66	25	3.27	3.40
	(.66)	(.75)		(.92)	(.93)
11	2.05	1.98	26	2.92	2.62
	(.75)	(.80)		(.67)	(.83)
12	2.12	1.98	27	2.71	2.57
	(.72)	(.85)		(.92)	(.94)
13	2.00	1.69	28	2.42	2.31
	(.87)	(.71)		(.71)	(.87)
14	1.66	1.62	29	2.78	2.67
	(.74)	(.73)		(.83)	(.85)
15	1.71	1.78	30	2.29	2.06
	(.77)	(.82)		(.69)	(.71)

Item Number	Caucasian	Ethnic Minority	Item Number	Caucasian	Ethnic Minority
31	2.29	2.08	46	2.51	2.40
	(.73)	(.67)		(.84)	(.73)
32	2.44	2.28	47	1.77	1.82
	(.69)	(.78)		(.78)	(.87)
33	2.69	2.56	48	2.08	1.98
	(.69)	(.81)		(.65)	(.69)
34	2.64	2.66	49	2.66	2.32
	(.85)	(.94)		(.76)	(.84)
35	2.51	2.56	50	2.32	2.30
	(.90)	(1.01)		(.74)	(.68)
36	1.70	1.86	51	3.48	3.18
	(.74)	(.93)		(.65)	(.77)
37	2.10	2.16	52	2.65	2.72
	(.81)	(.96)		(.84)	(.90)
38	1.74	1.82	53	3.48	3.36
	(.70)	(.80)		(.61)	(.56)
39	1.90	2.18	54	2.35	2.14
	(.78)	(.87)		(.66)	(.73)
40	1.75	2.08	55	1.62	1.68
	(.77)	(1.03)		(.56)	(.59)
41	2.34	2.34	56	3.04	2.41
	(.81)	(.90)		(.80)	(.96)
42	2.40	2.36	57	1.76	1.96
	(.89)	(.88)		(.62)	(.81)
43	2.33	2.36	58	2.71	2.76
	(.89)	(.90)		(.67)	(.77)
44	2.26	2.33	59	3.28	3.14
	(.82)	(1.00)		(.63)	(.70)
45	2.49	2.56	60	3.03	2.71
	(.83)	(.79)		(.64)	(.71)

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BIOGRAPHICAL SKETCH

Milledge Murphey was born in 1940, in Atlanta, Georgia, and is the oldest of three children. Following six years in Mississippi, he moved to Gainesville, Florida, to complete secondary education and the Bachelor of Science with High Honors degree at the University of Florida in 1962. That year, he married Carolyn Moody, from Fort Myers.

He then earned the Master of Science degree in Recreation Administration with Honors at Indiana University, Bloomington, Indiana. Following a tour of active duty as an Officer (1st Lieutenant) in the U.S. Air Force, he began work as a counselor with the Florida Division of Vocational Rehabilitation in 1965. In 1967, he was promoted to Supervising Counselor for the Gainesville District Office and in 1972 received the Master of Rehabilitation Counseling Degree from Florida State University. He was promoted to District Director of the Bartow District Vocational Rehabilitation Office in 1973, and in 1974 was promoted to the position of Regional Aging Program Coordinator in the newly created Florida Division on Aging. In 1975, he was promoted to Aging and Adult Services Program Supervisor for HRS District III, and received the Ed.S. in Educational Administration in 1977 at the University of Florida. During that year, he entered the doctoral program in counselor education, specializing in gerontology. Subsequently, he has been promoted to Director, Community Services

Program Office, with the Florida Department of Corrections in Tallahassee.

Mr. Murphey enjoys physical conditioning, jogging, and martial arts. He holds fifth degree black belt in Isshinryn Karate and third degree black belt in Kodokan Judo, and has participated at the international level in competition. He has taught both Judo and Karate in the University of Florida Physical Education Credit program, for the Gainesville YMCA, and at Santa Fe Community College for a number of years. His future plans include employment in a university setting in Counseling/Gerontology and additional research and publication in the field of aging.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Harold C. Riker, Chairman
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Hannelore L. Wass
Professor of Foundations of
Education

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